DOCUMENT RESUME

ED 365 603 SO 023 610

AUTHOR Niedergang, Mark
TITLE The Health Care Crisis in America. Public Talk Series.
INSTITUTION Topsfield Foundation, Pomfret, CT. Study Circles Resource Center.
PUB DATE May 92
NOTE 42p.
AVAILABLE FROM Study Circles Resource Center, P.O. Box 203, Pomfret, CT 06258 ($2).
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adult Education; *Discussion Groups; Futures (of Society); Government Role; *Group Discussion; *Health Care Costs; *Health Insurance; Leaders Guides; *Problems; Problem Solving; Public Affairs Education; Social Sciences; Study Guides; *Values
IDENTIFIERS Study Circles

ABSTRACT

This guide provides a framework for study circles to use in discussing the health care crisis in the United States. The guide begins with a background section that gives an overview of the health care crisis; then it presents a two-part framework for discussion. Part 1 focuses on the ethical issues that underlie any policy decisions. It points out the hard efficiency, equity, justice, freedom from government interference, and individual autonomy. Part 2 focuses on proposed reforms, first by looking at ways in which some states have restructured their health care systems and then by examining three basic approaches for health care reform on the national level. Discussion centers on presenting the strengths and weaknesses of each approach and examining how any of the approaches can satisfy the goals discussed in Part 1. The material is designed for use in 1-2 discussion sessions of 2 hours each. The guide also includes sources of additional information, suggestions for leading this discussion on health care, guidelines for leading a study circle, suggestions for participants, and a follow-up form. (KC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 365 603

STUDY CIRCLES RESOURCE CENTER

Public Talk Series

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

[signature]

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

THE HEALTH CARE CRISIS IN AMERICA

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has."
Margaret Mead

CG 025 410

BEST COPY AVAILABLE

Table of Contents

Introductory letter 1
Introduction * 3
Background: What's Wrong with Health Care in America? * 4
Part I – Ethical Issues: What Should Our Health Care System Provide? * 10
Part II – Policy Issues: How Should Our Health Care System Be Organized? * 15
Sources of Additional Information * 30
Suggestions for Leading *The Health Care Crisis in America* 31
Leading a Study Circle 35
Suggestions for Participants * 37
Follow-up Form * . . . . . inside back cover

* Material to be duplicated for participants

Primary author: Mark Niedergang
Editor: Martha L. McCoy

We are grateful for the assistance of

Rita Strombeck, Ph.D., President
HealthCare Education Associates, Laguna Niguel, CA

and

Mary Strong, Chairperson
American Health Decisions, Boston, MA
Citizens' Committee on Biomedical Ethics, Inc., Summit, NJ

Copyright 1992 Topsfield Foundation, Inc.

The Study Circles Resource Center (SCRC) is funded by the Topsfield Foundation, Inc., a private, non-profit, non-partisan foundation dedicated to advancing deliberative democracy and improving the quality of public life in the United States. SCRC carries out this mission by promoting the use of small-group, highly participatory discussions known as study circles. Please write the Study Circles Resource Center, PO Box 203, Pomfret, CT 06258 or call (203) 928-2616 for more information on study circles and the Study Circles Resource Center.

ADVISORY BOARD

Benjamin Barber
Walt Whitman Center for the Culture and Politics of Democracy, Rutgers University

Mary Birmingham
Member, A Library Network

Paul F. Ederson
Division of Continuing Education, State University of New York, Stony Brook

Peter Engberg
Kansas Teachers Association, Kansas Educational Association

Joseph Gladney
Center for Foreign Policy Development, Brown University

Joseph S. Nye, Jr.
John F. Kennedy School of Government, Harvard University

Jim Kerr Pumphrey
National Issues Forums

Frances Moore Lappé
Institute for the Arts of Democracy

Leonard P. Oliver
Oliver Associates

Sam Parent
National Conference of Diocesan Directors of Religious Education

Dorothy Shields
Adult Education Department of Education

David T. Taylor
Connecticut Conference, United Church of Christ

May 1992

Dear study circle organizer,

In a democracy, it is crucial that the public have input into the decisions government makes. Citizens must listen to a variety of viewpoints, consider the consequences of all positions, and make hard choices. The Study Circles Resource Center's Public Talk Series is based on this belief. The programs of the series are designed to assist in the discussion of critical social and political issues; each offers a balanced, non-partisan presentation of viewpoints.

The Health Care Crisis in America is provided to help your group discuss an issue that is quickly rising to the top of our nation's political agenda. Access to affordable and appropriate health care is a growing concern for many individuals and families. While all agree that change in the health care system is necessary, our society is at the beginning of a national dialogue about what kinds of changes we should make.

This program begins with a background section that gives an overview of the health care crisis, and then lays out two parts as a framework for discussion. Part I is the heart of the program; it focuses on the ethical issues that will underlie any policy decisions. Part II lays out the issues in the current policy debate on health care and encourages the integration of these with the ethical issues of Part I.

Organizing a small-group discussion on this issue

You will first need to decide how many discussion sessions to devote to the health care issue. The program was designed for use in two sessions of about two hours each. If your group will meet only once to discuss health care, we suggest that you focus on Part I rather than trying to discuss both parts in a single session.

You will then need to recruit between 5 and 20 participants, decide on a time and place for the meeting(s), select a discussion leader, photocopy the materials (participants will need copies of items marked with an asterisk in the table of contents), and distribute them to participants at least a few days before the meeting(s).

Your most important task is choosing the discussion leader. The leader should be able to encourage participants to freely express their thoughts while he or she preserves some focus to the session as a whole. A commitment to balance and impartiality is essential; expertise in the subject is not necessary, and in fact may be a disadvantage if it causes the leader to act as an "answer person." The leader should have enough familiarity with the subject that he or she is comfortable in guiding the group to weigh all points of view.

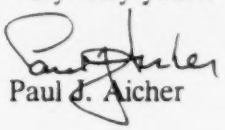
Organizing further discussions

The Study Circles Resource Center (SCRC) makes this material available in part to encourage discussion of this particular issue; our end goal, however, is to encourage citizen debate on the wide range of issues confronting our society, whether local, national, or international. We hope that this material will prove useful for a variety of organizations – educational, civic, religious, health-related, and others – that want to engage their members in open discussion of health care policy, and that it will also provide the impetus for regular use of democratic, highly participatory, small-group discussion.

Several options are available to groups wanting to carry on to discuss other issues. The back cover of this packet lists other programs in the Public Talk Series. Noted on that page as one of the publications we provide is a clearinghouse list of discussion programs developed by a variety of organizations. If your group would like to take on an issue for which no ready-made discussion package is available, a few good newspaper or magazine articles can provide the basis for dialogue. Please call us at SCRC for advice on developing your own study circle material.

We encourage you to initiate the rewarding discussion that takes place when concerned individuals meet in informal gatherings to discuss all sides of the critical issues facing our society. We also hope you will also communicate the outcomes of your discussion to relevant policymakers, for only then can your informed judgment influence policy.

Very truly yours,



Paul J. Aicher

Introduction

There is a general consensus that our health care system is in crisis, but as yet there is no consensus on what to do about it. The result is a growing national debate on health care reform - a debate whose result will affect the lives of millions of Americans.

The Health Care Crisis in America will help you and your group enter into the deliberation of this important issue. The program provides a framework for discussing the problems in our health care system and what our priorities should be as we try to reform it.

Participation in this study circle does not require specialized knowledge. The job of a citizen is the job of a generalist: if you develop thoughtful opinions about the basic ethical and policy issues, you will be able to provide important input to elected officials. Though this program is written primarily for the person just beginning to think about health care issues, it will also be useful for policymakers and health care providers.

After introducing some background information on current problems in the health care system, this program presents guidelines for a two-part discussion:

"Part I - Ethical Issues" is the core of *The Health Care Crisis in America.* This part provides a framework for discussing the beliefs and values that underlie the hard choices we have ahead of us as we attempt to reform the health care system. These tough choices derive from competing values such as fairness, efficiency, equity, justice, freedom from government interference, and individual autonomy. This part will help your group to weigh these values and consider what our health care system should provide.

"Part II - Policy Issues" focuses on proposed reforms, first by looking at ways in which some states have restructured their health care systems, and then by examining three basic approaches for health care reform on the national level. There are a multitude of reform plans, and many more are likely to emerge, but most of them fall into one of these general approaches or combine elements from several of them. By presenting the strengths and weaknesses of each basic approach, this part will help your group consider how well any particular proposal can satisfy the goals you discussed in Part I. It will also provide a way to understand the policy debate as it continues to unfold.

Ultimately, the shape of our health care system will be determined by decisions that are made by the president and Congress, and, to a lesser extent, by the governors and legislatures in the 50 states. You can be certain that health care will be a major issue throughout the 1990s. Candidates and elected officials will be looking to the public for guidance and political support. We hope that you will be better prepared to offer that guidance and support after participating in this program.

Background

What's Wrong with Health Care in America?

Health care is an issue which touches everyone. You probably have stories about the high cost of medical care or about problems with health insurance and how they have affected you or someone you know. You've probably known or heard of people having illnesses or accidents that aren't covered under their insurance policies, or about families that can't afford health insurance.

Many experts think that our health care system is approaching a breakdown. They cite the following facts and figures:

- An estimated 33 million Americans are without health insurance at any one time. Twice as many are without insurance at some point in each calendar year. Tens of millions more are under-insured.
- The U.S. government will spend $156 billion for Medicare and Medicaid in 1991, most of it for the elderly, while an estimated 9 million children and 14 million women of childbearing age have no health insurance.
- Increasing numbers of middle-class Americans are unable to obtain adequate health insurance after a layoff or job change.
- Medical costs are increasing at about eight percent a year, more than twice the general rate of inflation. At the current rate of growth, America's health care costs will double by the year 2000.
- The U.S. spends far more per person than any other country on health care, approximately 40% more than Canada (the next highest spender) and twice as much as Japan and Germany.
- Despite a high level of spending and the most advanced medical technology in the world, Americans are less healthy than people in many other nations. We are 15th in life expectancy. We rank 22nd in infant mortality and 21st in childhood mortality (the percentage of children who die in the first year of life and first five years of life, respectively), below some third world countries.
- Americans are not happy with their health care system. In a poll in 1988, 89% of Americans said that the health care system "requires fundamental change or complete rebuilding."

The list could go on and on.

Although our health care system is in trouble, it does have some redeeming features. Americans with full health insurance coverage may well receive the best medical care in the world. Polls reveal that most Americans, although dissatisfied with the *system*, are satisfied with their own personal health care. And Americans are not alone in disliking the system: people in most other nations dislike their health care systems, too. Only in Canada does a majority think their nation's health system works well.

Although the problems are varied, there are three key issues that always come up in discussions about health care in America:

1) Growing numbers of people without health insurance;
2) Inadequate coverage for many who are insured; and
3) The high and rising cost of health care.

1) Growing numbers of people without health insurance

Medical care for a serious illness or accident is so expensive that few people can afford it. Although most of us are healthy most of the time, we need financial protection just in case we become seriously ill. Health insurance is the answer.

The idea behind insurance is that everyone - the well and the sick, young and old, wealthy and poor - share the risk of a medical catastrophe and the costs of caring for the relatively few who need expensive medical care. Most people pay far more into the health care system in taxes, insurance payments (premiums), or through employer benefits than they will spend during their lifetime for health care. This excess pays for treating the unlucky few who need major medical care.

Most wealthy nations have established systems through which all residents have health insurance that pays for all medical expenses. In the United States, however, our health care system does not provide insurance for everyone, and the concept of sharing risk through insurance has been unraveling. Our setup is not really an organized system at all, but a patchwork of private and public programs - a quilt with holes.

Only about 87% of Americans have health insurance. Most people (59%) receive health insurance through an employer. (In most states, employers have no legal obligation to provide health insurance, however.) Another 7% have private, individual insurance which they purchase directly from an insurance company. The government provides health insurance to about one in five Americans through Medicare (11%), Medicaid (8%), or the military and Veterans Administration (2%).

That leaves one in every eight Americans (13%) - roughly 33 million people - without any health insurance at any given time. Almost twice as many people - 63 million - are without insurance for some period of time each year.

Who are the uninsured?

The vast majority of the uninsured are the working poor and their dependents. Sixty percent have jobs (most of them full-time) and another 15% are their dependents. Most of the uninsured are not poor enough to qualify for Medicaid and not old enough for Medicare.

A full 42% of the uninsured live in the South, the poorest region of the U.S. The uninsured are disproportionately non-white: one in four Hispanics has no health insurance, one in five blacks, but only one in ten whites. Surprisingly, 14% of the uninsured have incomes over $40,000.

The number of uninsured Americans has been rising steadily over the past 10 years, at the rate of about 700,000 people per year. The main reasons:

Government health insurance programs

Medicare

Medicare is a national health insurance program, created in 1965, for people aged 65 and over and the disabled. Medicare is funded through a small payroll tax on workers and employers, and through premiums that some people pay for an optional plan. Almost all older Americans, about 34 million people, receive Medicare. Medicare is not "means-tested" - rich and poor alike receive benefits.

The basic Medicare insurance plan covers hospital costs. The additional plan covers 80% of the cost of most other medical services, leaving recipients to pay the other 20% out of their own pockets. Many buy private "Medigap" insurance policies to cover this difference.

Medicare does not cover "long-term care" - the kind of care needed by people who are unable to care for themselves. Long-term care has become a problem because many older people spend their life savings in a few years if they need nursing assistance at home or require a stay in a nursing home. Then they must declare poverty and apply for welfare and Medicaid.

Medicaid

Medicaid provides medical benefits to poor people who are eligible for welfare programs. Most households with incomes below the poverty line are not eligible to receive welfare (because of provisions set by individual states), and are therefore not eligible to receive Medicaid. Although the program was not established to pay for long-term care, two-thirds of Medicaid benefits go to people who are old and disabled. Funding comes from the state and federal governments.

Because Medicaid is run by the states, benefits and eligibility vary greatly. For example, in Alabama, a family of four cannot receive Medicaid if its income is more than $1,416, while in Connecticut the figure is $9,278. Only 40% of households in poverty now receive Medicaid, compared to 65% in 1973. (In 1990, the poverty line was $6,652 for a single person, $10,419 for a family of three.)

- Some employers have completely cut health benefits.
- Increases in premiums have made it impossible for many households to afford private insurance.
- More people have part-time or temporary jobs, or work for small businesses that don't offer health benefits.
- High-wage manufacturing jobs have been replaced with lower-wage service jobs, many without health benefits.
- To save money, state governments have been tightening eligibility standards for Medicaid.
- An estimated 2 1/2 million Americans are uninsurable because insurance companies consider them bad risks.

The effects of lack of insurance on health care

What do uninsured people do if they become ill or have an accident? Many put off treatment until the problem becomes an emergency, at which point health care is less effective and more expensive. People who live near enough go to emergency rooms in public hospitals or to public clinics, but these facilities are often crowded and overwhelmed. Many of the poor live in rural areas and do not have transportation to distant public health facilities. Only in life-threatening emergencies are private hospitals required by law to give treatment regardless of insurance coverage.

One uninsured person's story

Louis Calderon is a nurse's aide and a single parent with two children. If he wants health insurance for his family, he has to pay an extra $45 a week. He cannot afford it; instead he receives $1.05 an hour in extra pay. He makes ends meet by working overtime, three or four extra shifts a week. But he is afraid that by working so much, he will be unable to provide his children with the attention they need.

Mr. Calderon recently paid off a $500 hospital bill for his son after taking him to the emergency room for an ear infection. His other son recently needed stitches, and Mr. Calderon is waiting anxiously for the bill.

The bottom line is that people without health insurance receive less medical care and lower quality care than those who have insurance. They are less healthy than the insured, partly because they are poorer, but also because they lack access to health care. A report by Georgetown University School of Medicine showed that hospital patients without insurance die at three times the rate of insured patients, partly because they arrive at hospitals sicker than those with insurance, but also because they are less likely to undergo costly optional medical treatments.

2) Inadequate insurance for many who are insured

All health insurance plans are not equal. At one end are "comprehensive" plans which cover all hospital and medical costs. At the other end are minimal "catastrophic" or "major medical" plans that cover only hospitalization and critical medical care. These minimal plans often require co-payments and have a deductible, sometimes as high as $10,000 per year.

Although employers' health insurance benefit plans vary widely, most have a core package that is fairly comprehensive, covering hospitalization and medical treatments for illness or accident. Frequently there is a deductible, but it is usually in the hundreds, not thousands, of dollars per year.

Medicare, if the optional insurance plan is purchased, is also fairly comprehensive. Medicaid coverage varies dramatically from state to state. In some states, recipients are often refused treatment because reimbursement rates are set so low that many doctors will not treat Medicaid patients.

People who are forced to purchase individual insurance pay far more than those who can obtain coverage as part of a group (for example, through an employer). Individual plans vary widely, depending upon needs, ability to pay, and willingness to take risks. Healthy individuals may decide to purchase a policy with a high deductible, while families with more medical expenses may prefer a more

expensive policy with a lower deductible. Young people in their 20s frequently go without health insurance: they don't expect to get sick, individual insurance is expensive, and they either need or want to spend the money for the here and now rather than for the security of health insurance.

Long-term care is a problem for people with private insurance, as it is for Medicare recipients. Because most insurance plans have an upper limit, and because the cost of long-term medical care is so high, it is estimated that 53 million Americans have insurance that is insufficient to cover a serious long-term illness.

Insurance terminology

Co-payment - The percentage of a medical bill which the person covered by a health insurance plan must pay. Often an insurance company will pay 80% of the bill and the individual must pay the remaining 20%.

Deductible - The amount that the covered person must pay during any given year before the insurance company will pay for medical bills. For example, suppose your deductible is $200, your co-payment is 20%, and your first medical bill of the year is $800. You must pay the first $200, and then 20% of the remaining $600, or $150. So you would pay a total of $350 and your insurance company would pay the rest, $450.

Exclusion - A health problem for which an insurance policy will not provide coverage, usually due to a pre-existing condition.

Pre-existing condition - A medical condition which exists prior to enrollment in a health insurance plan. In some cases, the insurance company will exclude this condition from coverage, or charge more for including it.

Provider - An individual (physician, nurse practitioner, etc.) or institution (hospital, clinic, etc.) that supplies health care.

Third-party payor - An organization that pays an individual's medical bills. For example, government is a third-party payor under Medicare, and insurance companies are third-party payors for those who have private health insurance.

An emphasis on treatment at the expense of prevention

Both private and government insurance plans cover medical treatments more than they cover preventive measures ("wellness" approaches to health). Since most health insurance does not pay for routine checkups, preventive tests, and health maintenance programs, many Americans neglect regular checkups and basic tests for cancer, heart problems, and other diseases.

This emphasis on treatment developed because most medical bills are paid by a third party - government or an insurance company - which wants to spend as little as possible and pay for only essential treatment. Ironically, the result is that overall costs are higher than if prevention were emphasized.

Another reason for the focus on treatment rather than prevention is America's passion for technology and skill in developing it. The U.S. is the world leader in developing new drugs, new medical procedures, and new medical machinery. American inventions and developments have saved untold numbers of lives; yet some see this as being at the expense of low-technology, low-cost, preventive techniques that might save even more lives.

The rise of health maintenance organizations (HMOs) has begun to change the way that the medical establishment thinks about health care. HMOs provide comprehensive medical care to enrollees; that is, they cover prevention as well as treatment. (In order to reduce costs, HMOs "manage care," limiting a member's choice of health care providers.) Some HMOs offer health promotion programs such as exercise classes and stop-smoking clinics because it saves them money in the long run. The success of HMOs has convinced some insurance companies to include preventive care as an option in their health plans.

Reductions and restrictions in coverage

A big problem for many individuals is that in recent years insurance companies have become far more particular about whom they insure and what medical procedures they will cover. Many Americans now find that when they have to replace their health insurance because they have switched jobs, lost

their jobs, or lost their health benefits in their current jobs, they cannot obtain the same coverage that they once had.

Commonly, insurance companies restrict coverage for pre-existing conditions - precisely those ailments which are most likely to require treatment. For example, if a person (or the person's spouse or child) has a diagnosed medical condition such as asthma, AIDS, chronic back problems, heart disease, or diabetes, a potential insurer may delay or deny coverage for that condition.

Fear of exclusion from coverage creates a scare

Barry Michaels, a 34-year-old unemployed urban planner, was paying to be covered under the health insurance plan his wife had through her employer. Hunting for a job during a recession, he was concerned about his career and his family's financial situation. He was also caring for a newborn baby at home.

When he began to have chest pains periodically, he dismissed it as stress. But after several months, he feared a heart problem. He also feared going to the doctor to have his heart checked: if a heart problem were to appear in his medical records at this time, it was likely that when he found a new job and changed insurers, his new insurance company would refuse to cover him for heart-related problems. So, against the advice of his wife, he decided not to see a doctor.

Mr. Michaels found a job five months later, had a full checkup and an electro-cardiogram after his new health insurance began, and was fine.

3) **The high and rising cost of health care**

A few facts give a sense of health care costs that are out of control:

- The United States has the most expensive health care in the world. We spend $2,354 per person per year - at least 40% more than any other country in the world.
- In 1965, health care consumed 5% of the gross national product (GNP); today it takes more than twice as big a chunk of the GNP, almost 12%.
- Health insurance costs for businesses rose over 20% per year in the late 1980s.
- American businesses spent more on health insurance in 1989 than they earned in total after-tax profits. Health care costs add $700 to the cost of Chrysler's American-built cars (but only $223 to the cost of its cars built in Canada, which finances its national health insurance system through the income tax).

Other nations also have problems with rising medical costs. All developed countries must deal with several factors that push costs up: the aging of the population, the AIDS epidemic, and constant improvements in technology and drugs that enable doctors to treat more diseases and extend life. But other nations have been more successful at controlling rising costs because their health care systems are nationally coordinated, better organized, and more efficient.

Why are medical costs in America rising so fast? The main reason is the complete lack of incentives to spend less. Since a third-party payor - an insurance company or the government - pays the vast majority of bills, neither providers nor patients have a reason to forego optional tests and procedures, even if the chance of success is low.

The inability to control costs has led to a situation in which each participant in the health care system tries to shift costs onto the others. Stuart Altman, a Dean at Brandeis University, described this cost shifting as "almost an art form where every major player figures out some way of 'sticking it to' their neighbor."

This cost-shifting "game" goes like this (and the beginning point could be anywhere):

- Government, not wanting to increase taxes, lowers payments for Medicare and Medicaid and tightens eligibility for Medicaid as more and more people seek assistance.
- Providers then charge more for their services in order to make up for lower payments by the government. The high cost of malpractice insurance and of processing medical claims also leads

to higher medical bills, as does the high cost of recently developed medical treatments.

- With higher charges, insurance companies have to put out more money to health care providers. Insurance companies pass on these higher costs, both to businesses and to individuals, in the form of higher premiums.
- Some businesses then discontinue providing insurance coverage for their employees, or cut benefits and require their employees to pay a larger share of their health insurance. In 1980, the average employee health insurance plan paid 80% of medical bills; by 1990 the figure was around 60%. As a result, health benefits have been the major issue in most strikes in the past few years.
- Individuals may become unable to pay out-of-pocket medical expenses or to purchase individual insurance coverage.

There are many different ideas about how to control health costs. You will find a discussion of this issue in "Part II - Policy Issues."

Growing numbers of uninsured, inadequate insurance for many who are insured, and the rising cost of health care have brought widespread calls for reform, if not for a complete restructuring, of the current system.

To solve these problems, however, we will need to make some difficult choices. Extending health insurance to cover 33 million people will cost a lot of money. Should a reformed health care system serve all Americans, even if it means that fewer Americans will obtain the highest quality care? Should we spend even more, or should we ration medical care? And if we ration, to whom do we deny what treatments?

These are tough questions. The next section focuses on ethical dilemmas such as these.

Why health care costs so much

- Our health care system focuses on treating the sick instead of on maintaining health. The result is costly medical problems which might have been prevented.
- The 33 million uninsured often forego treatment until they have an emergency (which often must be treated in hospital emergency rooms, where care is expensive).
- The U.S. health care system is extremely inefficient administratively. Providers must pay staff to fill out claims forms (sometimes as many as half a dozen forms per patient visit); insurance company and government employees are paid to decide whether to pay the claims. And the forms are not standardized - a serious problem, since there are 1,500 insurance companies, 50 states, and several federal agencies paying bills.
- There are no national standards for fees or for appropriate treatment, so there are no limits on what can be charged or on what tests or procedures can be done. This results in the perplexing - but not unusual - situation in which two hospitals in the same city charge wildly different prices for the same operation.
- There is no central authority (like the one that exists in most other nations) that can set and enforce spending limits.
- Because malpractice suits have been so prevalent, American doctors practice "defensive medicine," often ordering unnecessary tests in order to protect themselves in case of a lawsuit.
- America has more doctors who are specialists than do other countries, and specialists earn almost twice as much as general practitioners do.

Part I - Ethical Issues

What Should Our Health Care System Provide?

Many people are saying that health care is "*the* issue of the '90s." In order to play a constructive role in the national debate on improving the health care system, we must be clear about what we want our health care system to provide. Some goals will conflict with others; tradeoffs will be necessary. This section presents some ideas for discussing this difficult situation.

This will be the most important part of your study circle. The fundamental ethical questions about the goals of the system transcend discussion of specific reform plans. These questions are grouped under three broad headings:

1) Access to health care: Is it a right or is it a privilege?
2) Power to direct the system: How much for the government and how much for the private sector?
3) Rationing: Should we explicitly limit treatment for some in order to provide treatment for all?

1) Access to health care: Is it a right or is it a privilege?

A *right* is something to which people are entitled simply because they are members of society. When a society decides that something is a right, it creates an obligation for others to respect that right. Does society have an obligation to provide health care to all its members?

The history of health care in America suggests ambivalence on this question. While at times there has been strong interest in creating national health care - a system that would ensure that all Americans receive medical care - the sustained political support for such a commitment has been lacking.

Though interest in national health care has had its moments in our history, now is the first time since the early '70s that events have forced us to reconsider the question of whether society has an obligation to provide health care to all. Is access to health care a right?

Some Americans would say "No, there is no *right* to health care." A society is obligated to its members, but only to provide emergency care, and the United States already does that. National health care would be an unreasonable burden on society, they say, and it would require a larger role for government at a time when all levels of government in America are struggling financially. The middle class should not be forced to support the needy. We should not take another step toward the "cradle-to-grave" welfare state, the argument continues: too much security deprives people of the incentive to work.

Those who believe that health care is a right argue that as a wealthy society we do have a moral obligation to provide health care to all. In some cases, they argue, life itself is dependent

A history of national health care in America

The current arrangement in which employers provide health insurance for most Americans is not a planned system at all. It developed informally during World War II as a way to provide higher compensation to workers without raising wages, which had been frozen by law.

There have been several attempts over the past 50 years to pass a national health care law. After World War II, President Truman pushed for national health care, but opponents called it socialism; the anti-communism of the McCarthy era made new social welfare programs unattainable.

In 1965, the U.S. government created Medicare and Medicaid to provide health insurance for the elderly, the disabled, and the poor. Many believed these programs were just interim steps on the way to national health care. In 1973, President Nixon had substantial support for a national health care plan. But following his resignation after Watergate, the political momentum was lost.

upon access to health care; in many cases the quality of life is dependent upon that access. Supporters of national health care ask whether it is moral to allow people to die, or to live in pain and sickness, when we have the means to help. According to this argument, ability to pay should not determine access to health care. If we have to cut other government programs, raise taxes, or restructure the system in other ways, then so be it, they say.

While America has yet to decide whether health care is a right, all other developed nations except South Africa have established systems through which all of their residents have health insurance that pays for all medical expenses. This fact is often cited as evidence that the entire civilized developed world sees health care as a right. Opponents say that America is a more individualistic society than most other nations, with a tradition of less government involvement in personal affairs.

Those who believe that health care is a right must then answer other questions: What is the minimum that society is obligated to provide? How much health care is everyone entitled to? What are the limits of society's responsibility?

In answering these questions we tend to focus our attention on the poor. This is appropriate, for the poor need society's - and government's - help the most. What has changed in the past 10 years, however, is that medical care has become so expensive that increasing numbers of middle class people can no longer afford insurance. If we decide that health care is a right, society will need to help more than just the poor.

One thing that most Americans do agree on is that government, as society's agent, is responsible for seeing that society's will is carried out. Part of government's role is to lead, to make sure the health care system works, and to ensure that it reflects our values.

Should those who receive government assistance receive the same health insurance as everyone else? Do we want a system like Canada's in which everyone has comprehensive health insurance and is treated equally by the system? Or should government guarantee only a smaller, minimum package of health benefits to those it helps? If so, what should that minimum package include, and what medical treatments should be denied to people who cannot pay?

These are difficult questions. Most wealthy nations have already answered them, but America has not. We hope that you and your study circle will struggle with them and work toward your own answers.

Who is "the health care system"?

Our health care system involves many different players:

- **the individual**, as a patient, as a person who makes decisions about his or her own health each day, and as a buyer and/or recipient of health insurance coverage
- **businesses** (sometimes called the "private sector"), in the form of insurance companies, employers that provide health coverage, and manufacturers of drugs and medical equipment
- **the federal government**, which funds and administers Medicare and the VA hospital system, funds (along with state governments) Medicaid, supports medical research, and grants student loans to medical students
- **state governments**, which fund (along with the federal government) and administer Medicaid and regulate the insurance industry
- **local governments**, which run public hospitals and clinics
- **hospitals**, which exist in both the private and public sectors. Some private hospitals are run for profit and some are non-profit. Other clinics and hospitals are funded and run by the government.
- **providers**, the people (doctors, nurses, and other health professionals) and institutions (hospitals, clinics, and HMOs) that provide health care

2) Power to direct the system: How much for the government and how much for the private sector?

Thomas Jefferson said, "That government governs best which governs least." America has a political tradition of distrusting the national government. President Ronald Reagan's popularity was in part based upon an appeal to this streak of individualism and anti-government feeling. Some Americans believe that it is wrong for

government to create new social welfare programs, or that government is not qualified to play a bigger role in something as important as health care.

Another tradition in America, although not as powerful as individualism, is populism. Populism has been more distrustful of big business than of big government. Many Americans dislike big companies, especially banks and insurance companies, which are seen as faceless, heartless, and uncaring. Some Americans believe that private insurance companies' desire for profits is a big part of what's wrong with health care in America. Some just think that a system built around private profit will not work for the public good on something like health care.

Still others note that, despite these themes in the political culture, Americans have come to expect that government will take the responsibility for making sure that our basic needs are met, whether through public means, private means, or a combination of the two. While there are imperfections in any system, these people say that we should look for ways to ensure that government is more accountable to the public and that private power is regulated in ways that work toward the public good.

There are dozens of proposals for changing America's health care system, each with its own ideas about the proper roles for the public and the private sectors. Before weighing the particular proposals, you should consider your own view about how much power government should have in the health care system and how much power the private sector should have.

America's health care system is unusual because government - although it pays for about 40% of all medical costs - plays a small role compared to the role government plays in other developed nations. The private for-profit sector - led by insurance companies and employers - plays a much larger role.

How some other nations' health systems work

As with our health care system, these systems reflect their own cultures and societal values, and have been shaped by their particular historical experiences. Though most are considered more efficient than the American system, efficiency was not the only consideration when these systems were designed.

- Canada has national health insurance. Doctors and hospitals are in the private sector. People choose their own providers. The provincial (state) governments pay all the bills, set fees through negotiations with doctors and hospitals, and decide what new equipment doctors and hospitals can purchase.

- In Sweden and Great Britain, the government runs the health care system through a national health service. This is "socialized medicine." The government pays all the bills and decides how much money to spend and how to spend it. Most doctors work for the government and the government owns most hospitals. People choose their own providers.

- In Japan, 40% of the population has national health insurance through the government. Those who work for companies with over 700 employees receive insurance through their company, and others are covered through non-profit "Mutual Aid [insurance] Associations" that are organized by craft (e.g., teachers, seamen).

- Germany's system features 1,200 non-profit insurance companies called "sickness funds." Employers and employees have to pay taxes into the funds, which then pay for health care. Direct government spending accounts for only a small portion of the total. But government is heavily involved as a regulator, overseeing negotiations between the sickness funds and providers to keep prices down.

Most of the reforms that are proposed for the American health care system call for a larger role for government. The question of how much power the government should have leads to another critical question: "How should decisions about who receives health care be made, and who should make them?"

Canada vs. the U.S.: The power of the government

In recent polls, Americans have reacted favorably to the idea of a national health insurance system like Canada's. In Canada, provincial governments make all policy decisions about health care - from which machines hospitals can buy, to what treatments will not be provided to the elderly when it seems

that treatment will not significantly extend life. Because of shortages of expensive machines and operating rooms, Canadians may have to wait several months or longer for some expensive tests and for elective surgery. Although private doctors decide who advances to the top of the list and who must wait, decisions by government create the shortages.

Despite this, Canadians are more satisfied with their health care system than anyone else in the world. In Canada, the provincial governments ration health care: by saving money on expensive machines and facilities, they are able to provide excellent basic health care for all citizens. As a result, overall, Canadians are healthier than Americans, even though some people cannot obtain the treatment they want.

What do you think would be the advantages or disadvantages of such a system for the United States? Does a system in which the state governments have these powers appeal to you?

The power of employers and insurers

In America, decisions about who receives health insurance and medical treatment are mostly made in the private sector, by employers, insurance companies, and health care providers. The government's power derives from its role as a regulator and as a provider of Medicare and Medicaid. One result of this system in which the private sector plays the major role: there are plenty of high-tech machines and operating rooms here, but you may be denied treatment if you don't have insurance. Doctors and hospitals turn away an estimated one million Americans each year because they cannot pay for medical services.

In America, businesses are the main providers of health insurance. Three of five Americans are covered under insurance plans which their employers purchase. But in the past decade, many businesses have required larger employee contributions, reduced their health plan's coverage, or cut health insurance altogether.

Many businesses that provide health insurance to their employees are bending under the burden. In a survey of top business leaders in 1991, 87% said that their companies will not be able to bring their health care costs under control in the next two years. Should employers be the insurance providers in our society? What are some of the benefits of this arrangement? What are the disadvantages? Is this setup consistent with the values you consider to be most important? For example, this system ties people to their jobs, thereby limiting their freedom of movement and career mobility. Is this a necessary price to pay in order to retain some private-sector influence in the system? Some argue that the present system provides work incentives that benefit the entire society.

Private insurance companies can deny health insurance coverage to anyone for any reason, can restrict coverage, or can set the price as high as they wish. The only limit is "the market" - competition with other insurance companies. Over the last few years, more and more people have become unable to buy adequate insurance. How do you feel about the power that private insurance companies have in our current system? Would you rather the government have that power?

Who should decide?

Who should have the power to decide who obtains insurance and who doesn't, who receives medical treatment and who doesn't? Whether the government or the private sector makes these decisions, there are both advantages and disadvantages. (And of course there are many possible ways to implement either approach, as well as ways to combine them.) While officials at private companies are accountable only to their owners, government officials are elected or are appointed by people who are elected. There is more public accountability if government plays the dominant role since officials have to stand for re-election. The threat of being voted out of office in the next election makes them sensitive to public pressure.

But many think that government makes a mess of most everything it runs or regulates. Americans don't like government bureaucrats telling them what they can or can't do, and many think that people in the government are not particularly honest or trustworthy. Those who have trouble believing in government accountability would not trust government with the nation's health care system.

Many Americans have higher regard for local and state governments than for the federal government in Washington. Because the federal government has not acted to reform the health care system, the states are becoming increasingly involved in health care policy. A big motivator for states is that they share financial responsibility for Medicaid with the federal government, and Medicaid costs have been increasing so fast that they are "busting" state budgets.

As a result, several states have implemented innovative programs, and many others are in the works. Massachusetts has a law on the books which will extend insurance coverage to all residents, and Illinois, Missouri, Vermont, and Washington are considering or developing plans for publicly financed health coverage. Do you feel differently about your state government being involved in health care than you do about Washington's involvement?

3) **Rationing: Should we explicitly limit treatment for some in order to provide treatment for all?**

Nobody made a conscious decision that roughly 33 million Americans should not have health insurance. Nobody decided that millions of infants, children, and pregnant women should not receive medical care. Nobody is proud that the infant mortality rate for many inner city neighborhoods is higher than in many third world countries. Yet these are the outcomes of the current system: this is how our system implicitly rations health care.

Whether and how to explicitly ration health care are the ultimate questions of values. We have limited resources: on what and for whom should we spend them?

Oregon Plan author defends rationing of health care

John Kitzhaber, a practicing physician and President of the Oregon State Senate, said in an interview with *Parade Magazine*:

"It's hard for Americans to admit it, but this country does ration health care. And we do it in ways that are unfair and inefficient. For example, we spend over $50 billion a year on people in the last six months of their lives, while closing pediatric clinics. We spend over $3 billion a year on intensive care for newborn babies, while denying prenatal care to hundreds of thousands of pregnant women." (Donald Robinson, "Who Should Receive Medical Aid," *Parade Magazine*, May 28, 1989, p. 4.)

Rationing in some form exists in every health care system. No society is willing to spend enough money to provide all the medical care that everybody needs or wants to stay alive as long as they can. With advances in medical technology, it is now possible to spend enormous amounts of money if doctors try every procedure that might work, no matter how slightly it might extend life or how low the probability of success.

In most nations rationing is up-front and explicit; government officials set guidelines for which illnesses should be treated and how they should be treated (by setting guidelines for which treatments will be paid for). Doctors then use these regulations as they decide what type of treatment a patient should receive.

The health care system in the United States is decentralized, and yet there is still rationing - it happens indirectly as an unplanned outcome of the interaction of private decisions (made by individuals, employers, insurance companies, and health care providers) and public decisions (made by the federal and state governments). For example, the major way in which health care is allotted is through private health insurance: those who do not have health insurance are denied access to many kinds of treatments. Most Americans do not think of this as a question of rationing, since it is not the result of an explicit plan. Because of our political culture, explicit rationing may seem less acceptable than the rationing that takes place as the outcome of a system that is largely privately run.

One experiment with explicit rationing in the United States is taking place in Oregon state. (We reprint an article about the Oregon plan in Part II.) In an effort to cover more poor people under Medicaid, in 1987 the Oregon State Legislature decided to stop using Medicaid funds to pay for heart, liver, bone-marrow, and pancreas transplants. Instead, the approximately $2.3 million that is saved each year is to be used to provide prenatal care for needy pregnant women. In December 1987, Coby Howard, a seven-year-old boy with leukemia whose mother was on Medicaid, died after Oregon refused to pay for a bone-marrow transplant. There was public outrage. On the other hand, the plan has won some acclaim, since as it is envisioned (parts of the plan are not yet implemented) everyone in the state would be assured a minimum level of care. What do you think about the Oregon plan? Should other states adopt similar approaches? Should our nation as a whole adopt such an approach?

An example of the high cost of medical care for the elderly

Mrs. Landros, a widow, is a smoker. At the age of 69 she developed emphysema and went into the hospital for three weeks. She recovered and went home. At 75, Mrs. Landros had to have an expensive operation to replace her hip joint. It took her three months to recover, but the operation, a fairly new one, allowed her to walk again.

At 79, Mrs. Landros had a serious stroke. For several days it was unclear whether she would live. After a few weeks she entered a nursing home. But the stroke left her unable to walk and slurred her speech. She could no longer take care of herself.

Over the next year, her condition deteriorated and she became more and more confused. Finally she developed chest pains and could not breathe. Her heart stopped beating. She was rushed to the hospital, and an electric shock started her heart again. Drugs were used to regulate her heartbeat, and a tube was surgically implanted in her windpipe so she could breathe.

Finally, a month later, Mrs. Landros died at the age of 80. Her medical care had cost hundreds of thousands of dollars, most of it in the last few months of her life.

Tough choices in health care

A *New York Times* article described meetings run by the Vermont Ethics Network, a group that sponsors public discussion of health care issues. Participants were asked to pretend they were policymakers for a state of Vermont health plan that guaranteed basic coverage to all Vermonters.

Due to limited state funds, they were asked to decide which one of four new technologies to add to the plan for the coming year:

1) an improved arthritis drug treatment that would help 33,000 people a year;

2) an intensive monitored exercise program for heart attack patients to help 1,000 people from the ages of 40 to 55;

3) breast cancer detection through mammograms for 35,000 women a year; or,

4) an experimental system for helping premature newborns breathe which would help 100 babies a year.

Providing each of the new treatments would cost the same, but each would help different numbers of people in different age groups and with different needs. Much additional information about the likely success of the treatments would be available to real policymakers, of course, but this example shows how gut-wrenching health care policy decisions can be. "The idea of making such life-and-death choices made many of the participants squirm in their folding chairs." (Sandra Blakeslee, "Tough Medical Choices: Letting the People Decide," *New York Times*, June 14, 1990.)

Those who support explicit rationing realize that some people with serious illnesses will go untreated, but they point out that the money saved could go toward less costly treatments and thus benefit many more others. Although rationing can control costs, the basic argument for it is moral: by providing more treatments that benefit larger numbers of people, society can do greater good for a greater number than by treating fewer people with more expensive treatments.

Because much of the care given early in life is more preventive in nature (and less expensive) and the most expensive treatments tend to come in the last years of life, many rationing questions come down to tradeoffs between the young and the elderly. The vast majority of government expenditures go for the elderly, either through Medicare or Medicaid, a trend that some people believe must be changed. In Great Britain, for example, the National Health Service ordinarily does not

provide kidney dialysis for anyone over 55. What do you think about these tradeoffs? Is it unfair to withhold some treatments to older people, who have already made their contributions to society? Is a woman who acquires AIDS through using needles to inject drugs, or a man who needs medical treatment because of alcoholism, more deserving of medical care than is an elderly person?

Opponents of explicit rationing argue that it gives the government the power to dictate choices to private citizens. This is not desirable, they say. Individuals and their doctors should be able to decide what type of treatment is appropriate without government interference.

To answer this question, we need to be clear about what we value in a health care system. What should our priorities be? Do we want to invest more in research to continue to develop new medical technology and drugs that can save lives? Should maternal and child care be our top priority? Do we have a commitment to treat elderly citizens with all available medical technology? Should we spend more on public health campaigns that emphasize basic health for all?

While we can pursue many of these goals, we cannot accomplish all of them. Which of these goals should we fully fund, and which should we fund only after other priorities are satisfied? Even if we do not make explicit choices in answer to these questions, we are making choices by default; public consideration of these questions is vital.

Part II - Policy Issues

How Should Our Health Care System Be Organized?

This part of *The Health Care Crisis in America* focuses on the more political issues, in particular on the question of how our health care system should be organized. Understanding these issues can seem daunting. As U.S. Representative Peter A. DeFazio, a Democrat from Oregon, told *The New York Times*: "The more you delve into the issue the more complicated it gets." In spite of the complexity of the health care system, citizens can gain the broad understanding they need to offer thoughtful guidance to elected officials.

As concerned citizens, we need to decide what type of a health care system our nation should have and how that system should work in the broadest sense. In this part of the program, we provide a framework that will help your group put the maze of details into the context of the big picture.

Part II begins with a brief history of cost-containment efforts, since the control of costs is one of the two central issues in the health care debate. (The other central issue, access to health care, was largely covered in Part I.) This brief review will help your group judge how well different types of health care plans might control costs.

Following this is a section that examines reforms that some states have made in their health care systems. These states have restructured their health care systems in order to expand access and cut costs. Their reforms provide possible models for other states and for Washington; we reprint articles describing health care reform in two states. We also include some suggestions for finding out about your own state's health care system.

Part II concludes with a look at the debate about reforming the national health care system. As of January 1992, more than 30 different bills to change the health care system had been filed in the U.S. Congress, and there will certainly be dozens more. Most of the reform plans fall into one of three distinct approaches: individual insurance, employer mandates, or national health insurance. We describe these three approaches and reprint newspaper articles about a leading plan from each category.

When you discuss these policy issues, we hope you will keep in mind the ethical questions raised in the first part of this program. Also keep in mind that no health care plan can achieve every goal we deem important; that is, any kind of health care reform will require tradeoffs. We encourage you to consider the plans described below in light of how likely they are to achieve the goals that you think are most important.

1) Controlling costs – What will work?

Two issues stand out in the health care policy debate: access to health care (addressed in the Background and in Part I) and controlling costs. To help you judge how well different types of plans might control rising health care costs, this section provides a brief history of cost-containment efforts.

The high cost of medical care goes hand in hand with expensive health insurance. The results of uncontrolled costs are often sad, and sometimes tragic. For the past decade, businesses and insurance companies have been trying to control medical costs - without success.

Cost containment is a complicated topic. As was pointed out earlier in "Background: What's wrong with health care in America?," the main reason for high health care costs is a complete lack of incentives for providers to reduce costs or for consumers to use health care economically.

A variety of initiatives for controlling costs have been tried over the past decade. However, each has been thwarted by another part of the health care system. For example:

- The federal government instituted stricter standards for reimbursing doctors under Medicare and reduced payments for some procedures. In response, some doctors and hospitals have performed more procedures, so overall costs have not gone down.
- State governments set reimbursement rates for Medicaid that are substantially below what doctors and hospitals normally charge. Now many doctors and hospitals refuse to treat Medicaid patients. Those who continued treating Medicaid patients then raised the fees they charged to private patients, both insured and uninsured, to cover the difference.
- Insurance companies review bills more carefully, often refusing to pay for certain tests unless they are justified in writing beforehand or approved by a second doctor. However, providers are hesitant to pass up tests lest they be sued for malpractice. Furthermore, there is no incentive for doctors to forego tests.

Reforms proposed to contain costs

- Standardize paperwork to reduce administrative costs.
- Create a standardized national fee structure to reduce overcharging.
- Create a national board to set spending limits on new equipment and facilities.
- Make it harder to sue doctors for malpractice and to win suits, and set an upper limit for monetary damages. These protections will free doctors from the need to practice "defensive medicine" (that is, performing tests and procedures primarily for protection against legal action).
- Fund quality control research to provide information about what medical procedures and tests are necessary, which treatments work, and which providers are efficient.
- Provide cost information and encourage businesses to set up "managed care" plans that use more efficient providers.
- Provide incentives for health maintenance and prevention.
- Pass state laws to create statewide "risk pools" that would combine small groups and individuals into a single, large group. This would lower insurance costs for small businesses and individuals and end exclusion of people with preexisting conditions.

A small business that can't afford health insurance

This story appeared in a documentary, *The Health Quarterly*, on public television in June 1991.

Don Summers, a businessman who runs a small, family-owned welding company in Austin, Texas, can no longer afford health insurance for his workers. In April 1991, after months of struggling to find affordable health insurance, Summers told his story to the U.S. Senate Finance Committee in Washington.

"I believe it is my moral responsibility to take care of my people," he said. "I have to come face-to-face with them every day. I don't have a board of directors to hide behind."

Summers described how, shortly after he called his employees together to tell them he could no longer provide them with insurance, he personally confronted the consequences of his decision. Chatting with one of his employees in the supermarket, he learned that his worker's wife was expecting a child - and facing thousands of dollars in prenatal care and delivery fees.

When he finished telling his story, Summers said, "Oh Lord, a 21-year-old man with a pregnant wife making $10 an hour. Lotsa luck, young man. Something must be done."

Some experts believe we must restructure the entire health care system before we can control costs. Advocates of individual insurance plans argue that only vigorous free-market competition will contain costs; those who support national health insurance believe that government must run the health care system to make it efficient. Those who favor employer mandates do not want to restructure the current system. They want the government, as the strongest player, to enact a variety of administrative, legal, and regulatory reforms. They believe that a combination of measures will reduce costs.

Deciding what new system or what reforms are likely to control health care costs is not an easy task. Which reform measures are most likely to work?

21

Given the history of cost-containment efforts, do you think reforms can be effective, or must we completely restructure the current system?

In discussing how to control costs, we are in all likelihood talking about how to limit the *increase* in costs. Costs are likely to rise faster than general inflation under any health care system, especially if we attempt to increase access to the health care system. The question may be, what rate of increase can we tolerate? At some point, might we have to place a limit on public spending for health care, and then decide how to divide the available funds?

Who should pay for the rising costs of medical care? Should the current burden be redistributed, and if so, how? Each of the proposed health care plans would redistribute the current burden in different ways.

Health care costs will continue to rise

Four factors are likely contribute to steadily rising health care costs in any proposed system, given current demands and developments:

- An aging population. The percentage of Americans over 60 will rise from 13% today to 20% by 2030. Since it costs more to care for the elderly, the total amount we spend will rise.
- Continued improvements in drugs and medical technology. These save lives, but at a cost.
- The AIDS epidemic. Treatment for AIDS patients is long-term and expensive.
- Expanding access to health care. It will cost money to provide health care for the uninsured.

Ultimately, we are all likely to pay more as health care costs continue to rise. We will pay higher doctor and hospital bills. Since government is heavily involved in health care, we will pay through cuts in other programs or higher taxes. (The tax laws, however, will determine how the tax burden is distributed.) We will pay through higher insurance premiums. We will pay through higher prices for American products and services, because companies must raise prices to cover the cost of providing health insurance to employees.

The only potential ways to avoid higher health costs would be to: a) make the system more efficient through major changes in our health care system; b) limit access to certain treatments for some people in unprecedented ways; or c) restrict spending on new medical technologies. Some would say that many or all of these cures are worse than the disease. But others say, "Where will it end?" In April of 1991, Richard Darman, Director of the Office of Management and the Budget for the Bush Administration, projected total health spending at 17% of gross national product by the year 2000 and 37% by 2030.

2) State Reform Efforts

Although state governments have far less power over health care than does the federal government in Washington, more and more state legislatures and governors are acting to reform the parts of the health care system that they control. Almost two dozen states have passed or are considering legislation to fill the policy vacuum created by Washington's inaction on health care. They have acted because the problems of access and runaway costs are having a tremendous impact on state budgets and on the quality of life for many people.

State governments are involved in the provision of health care in a variety of ways. They are partners with the federal government in Medicaid, and generally provide about half of the funds for that program. Also, states provide health insurance as a benefit for state employees. They also provide a good part of the funding for public hospitals, run by cities and counties.

The cost of these programs is high and growing higher every year. In fact, health care expenses - particularly Medicaid and health insurance for public employees - have increased so much in the last ten years that they are among the leading causes of state budget crises.

Budget problems alone would have forced many states to take action. But another driving force behind these changes is the close connection between state-level elected officials and their communities. State legislators have been confronted frequently with constituents' difficulties in obtaining adequate and affordable health care.

State governments do not have the legal and regulatory power or the control over several hundreds of billions of dollars of health care spending that gives the federal government so much power in our health care system. But most states have a variety of levers they can use to affect health care within their borders. For example, the states set the income standards that determine who qualifies for Medicaid. They regulate the insurance industry. They decide what kind of health benefits thousands of state employees receive. They license and set professional standards for doctors, nurses, and other health professionals. Some states have review boards that are empowered to grant or deny hospitals' requests to purchase expensive new technology. And all states can levy taxes, which can be used to fund health care programs.

Each state's health care system is unique, but there are similarities among state systems as well. In order to initiate discussion about state-level reform, this program contains reprints of two articles: 1) "Closing the Health Care 'Gap Group'," which describes reforms already made in Hawaii's health care system; and 2) "For Oregon's Health Care System, Triage by a Lawmaker With An M.D.," which explains the changes that Oregon has proposed for Medicaid. Both the Hawaii and the Oregon proposals were motivated by the desires to expand access to health care and to limit the cost to the state.

The Oregon proposals in particular have received much attention in the policy debate at the national level. In August 1992, the Bush administration denied approval of the Oregon plan, stating concerns that it violates the Americans with Disabilities Act of 1990. Oregon officials are revising the plan in order to reapply for the waiver of certain Medicaid regulations that would be required for federal approval of the plan.

It might be helpful to discuss your own state's system in light of the reform efforts in Oregon and Hawaii. To do so, your group will need to have some basic knowledge about your state's health care system. Unless someone in your group has this knowledge, you may have to do a little research.

A few members of your study circle might make some phone calls. They could talk to a health professional with whom they are acquainted. A call to your state representative's, governor's, or city councilor's office may result in a package of information. Your state's department of health may be helpful. You can also find some articles about the system in local newspapers.

With this information, your study circle can discuss some of the following questions: How does your state deal with the key issues of access and controlling costs? Are there any lessons from other states that might be applied in yours? What types of changes do you think should be made in your state's system?

Change is much easier to bring about on the state level - where a small group has more clout - than on the national level. If you have any ideas about how to improve your state's health care system, we encourage you to share them with your state legislators by writing to them or meeting with them.

Questions to keep in mind as you investigate your state's health care system

- How many uninsured people are there in your state? What groups are more likely to be uninsured?
- What is being done or has been done to expand access?
- Who qualifies for Medicaid?
- Are there programs to cover the unemployed? Are there programs to cover those who are too poor to buy insurance but not poor enough to qualify for Medicaid?
- Where can people without health insurance get health care?
- What has been done to control costs?
- Are businesses in your state having trouble with health care costs? Is anything being done to help them?

While some states can take significant steps to improve the health care that their residents receive, other states will not be able to go it alone. Poor rural states and states with big cities may not have the financial resources to provide adequate health care for all their residents.

Ultimately, only the federal government has the power and financial resources to make sweeping changes that will dramatically cut health care costs and expand access. A solution to the health care crisis in America requires the involvement of the United States government. The remainder of Part II focuses on approaches for reform at the national level.

3) Approaches to Health Care Reform at the National Level

Although the federal government has much more influence over the health care system than do the state governments, Congress and the president have been slower to act to change the system. This is due partly to disagreement over the appropriate role for the national government in a reformed health care system. Still, most people look to Washington for leadership.

Scores of different plans have been proposed for health care reform at the national level. They have come from doctors, economists, business leaders, and elected officials. Most of the reform plans fall under one of three general approaches: individual insurance, employer mandates, or national health insurance. The remainder of this section describes these three primary approaches and includes some of the objections to each. Since there are many different plans based on each of the three general approaches, the description of each approach is general. We focus on how each approach proposes to provide coverage to the uninsured and to control costs.

Considering the proposals

As you discuss the proposals, try not to get lost in details or in disagreements over factual questions. What's most important is whether the overall approach can work and what it is likely to achieve. Try to assess the pros and cons, the potential benefits and the potential costs.

- How realistic and practical is the proposal? What obstacles to efficient implementation do you foresee?
- How does the plan propose to expand access to health care, and how effective is it likely to be?
- How well will it control costs, and at whose expense?
- Which values does it emphasize? Which values does it de-emphasize?

To provide a concrete example of each approach, we include a newspaper article that describes a leading plan from each category. Specific plans for health care reform may not stick religiously to one of the three philosophical approaches. For example, the Bush Administration plan is not a pure example of the individual insurance approach; it calls for government regulations to reform the small business insurance market, a recommendation usually advanced by those who favor employer mandates. However, we hope that by discussing the basic approaches you will be better prepared to evaluate specific plans. The political debate on health care is still fluid; specific plans are changing and new plans are being proposed. If there are other specific plans that members of your study circle would like to discuss, we encourage you to add articles for group members to read.

If you understand these three general approaches you will have sufficient background to participate in the debate about health care reform. As you read on, and in your discussion, consider which approach is most likely to provide a workable health care system for America and to achieve the goals you think are most important.

Individual Insurance

In contrast to employer-provided health insurance that is the basis for our current system, the individual insurance approach argues that individuals and families should be responsible for buying their own insurance. Plans that fall into this category propose the use of federal tax incentives (tax breaks) to help the middle class and the working poor afford private health insurance. Either Medicaid or vouchers would provide health care for the poor. (A voucher is a certificate from the government

worth a certain amount of money that can be used only by a specific individual for a specific purpose, such as the purchase of a health insurance policy.)

These plans rely upon free-market competition to control costs. Proponents believe that if individuals and families are responsible for buying their own health insurance, they will have an incentive to be cost-conscious consumers. As a result, competition among insurance companies for customers would drive down insurance *and* health care costs.

The direct cost to the federal government of this type of plan would depend upon the size of the tax credits and the income level at which recipients would qualify. One estimate is $100 billion over five years.

Some of the arguments against individual insurance

- The tax credits will be too little to help; many of the uninsured will be unable to buy insurance. Even those who are helped will only be able to afford policies with high deductibles and co-payments.
- Free-market competition will not control health care costs because health care is not a consumer product like a car, a TV, or a VCR. People will spend without limit when health is at stake.
- Health insurance options are extremely complicated; many consumers will be unable to make cost-effective decisions about which policy to purchase. Even worse, they may end up with the wrong type of policy, one that doesn't offer adequate coverage.

The Bush Administration's health care plan, described in *The New York Times* article, "Bush Unveils Plan for Health Care," relies primarily upon individual insurance but has other features as well. The Heritage Foundation in Washington, DC, also favors the individual insurance approach.

Employer Mandates

Plans using the employer mandate approach would expand the current system, in which 60% of Americans are insured through their employers. Businesses above a certain size would be required by law to provide insurance to employees. Smaller businesses would have to "play or pay": they could "play," by providing insurance, or they could "pay," by opting for a special payroll tax (6-8 percent) for a public insurance program. The public insurance program would provide or sell health insurance (depending upon income) to all those without coverage. Under some employer mandate plans Medicaid would be retained, and under others public insurance would provide for the poor.

To control costs, the government would establish a national board, consisting of representatives from the medical community, hospitals, private insurers, employers, consumers, and government. This board would set yearly spending limits for health care and would oversee negotiations between payors and providers to set fees.

Due to the cost of providing insurance to the poor and unemployed, this plan would cost the federal government tens of billions of dollars per year when fully phased in.

Several Democrats in the U.S. Senate, led by Majority Leader George Mitchell of Maine, are supporting a plan that relies on the employer mandate approach. Their plan is described in Senator Edward Kennedy's article, "An Affordable Health Care Plan for All," and the ac-

Some of the arguments against employer mandates

- In forcing employers to pick up most of the price tag for national health care, we will further hamper the competitiveness of American companies. Small businesses in particular will be hurt.
- This approach is unlikely to contain costs. There will be no new incentives for providers to reduce unnecessary tests and procedures. The more than 1,000 payors in the system (insurance companies, the federal government, and the state governments) will still lack the leverage to get providers to reduce fees.
- The inefficiency of the current system will remain. But, with the government more involved than before, there is apt to be even more paperwork.

companying article, "Troubled Health Care System." The American Medical Association and many other organizations also favor this approach.

(Two other reform approaches that are receiving some attention, "managed competition" and expansion of Medicaid and Medicare, are essentially employer mandate plans. Neither has strong support in Washington at this time.)

National Health Insurance

Under this approach, which would completely restructure the American health care system, the federal government would provide health insurance for all. All Americans, regardless of income, would be entitled to the same comprehensive health care. There would be no bills to individuals or insurance companies, and no deductibles or co-payments for individuals to pay. Doctors and hospitals would remain in the private sector, and people would still have a free choice of their health care providers.

By doing away with all private insurance companies and current government programs in favor of federally provided health insurance for all, advocates say that costs and inefficiencies would be reduced tremendously. State governments would set budgets for health care and regulate large expenditures. They would also decide upon medical priorities, such as which treatments would be immediately available and which would require a waiting period.

Some of the arguments against national health insurance

- Americans will not accept a system like Canada's, which has waiting lists for tests and elective operations. Americans don't want government to have the power to place limits on access to some medical treatments.
- National health insurance would stifle technological innovation in health care. America would lose its premier position in developing new medical technologies and drugs.
- Government in America is inefficient and is likely to make more of a mess of health care instead of improving the system.

Advocates say that a national health insurance system would not increase total health care costs at all. They believe that the system's greater efficiency would save enough money to provide health insurance to all of the uninsured. However, an estimated $250 billion would need to be collected through taxes to replace insurance premiums, employer-provided health insurance, and individuals' payments for medical bills.

The Christian Science Monitor article, "Single-Payer System Guarantees Health Care for Less," describes the plan put forward by U.S. Representative Marty Russo (D-IL). Senator Bob Kerrey (D-NE) has also put forward a plan based on this approach.

If Congress and the president enact health care reform legislation, it's likely that no one of these approaches will be followed exclusively. There are likely to be compromises among proponents of different approaches. If you communicate with your elected representatives about the general approach to health care reform you favor - whether it is one of these three, a combination, or one not described here - you will be making a contribution to the policy debate on health care.

Since our government is elected and controlled by the voters, citizens can have an impact on the health care crisis. We hope this program will encourage and help you to contribute to the debate over national health care reform.

The following article describes health care reform at the state level.
Reprinted by permission of the author.

Boston Globe, March 12, 1991

Closing the health care 'gap group'

LOU CANNON

HONOLULU – Dr. John Lewin is a spare-time marathon runner with a long-distance vision of a nation in which everyone receives prepaid health care.

"I think basic health care is a fundamental human right," says Lewin, the state director of health in Hawaii.

But this former family physician and health officer for the Navajos is convinced that this right can best be realized not through a Canadian-style government health service but by vigorous American-style competition among health-care providers. What Lewin wants the government to do is provide the incentives – or the mandates – that will require this kind of competition.

Hawaii has long been an example in the art of providing health care for working people at a price even the smallest employer can afford. Since 1974 it has been the first (and only) state requiring employers to provide health insurance to all their full-time employees. While businesses can require employees to pay half the cost of this insurance, and coverage of dependents is optional, the coverage is mandatory for full-time workers. In practice, most dependents are covered by some health-insurance plan.

Because of its law requiring health coverage for workers, Hawaii has by far the nation's lowest "gap group" – the term applied to those too young for Medicare, not poor enough for Medicaid and unfortunate to work for an employer who lacks an insurance program.

And last April, at the urging of Lewin and the state's progressive Democratic Gov. John Waihee, Hawaii passed another first-of-its-kind law extending health insurance to the 35,000 persons (a little more than 3 percent of the population) who formed its gap group: the self-employed, part-time and seasonal workers, homeless unemployed, and some dependent children.

In comparison with other visionary health programs, notably Massachusetts', the emphasis in Hawaii has been on prevention through regular physical examinations, mammograms and prenatal care. The result has been not only a healthier population but low costs that have prompted competitive bids from insurance companies.

Hawaii's health care has become nearly universal at a time when most of the country is heading in the opposite direction. The number of Americans who lack any health insurance is increasing. These are people who rely on hospital emergency rooms for their medical care.

According to some estimates, as many as 40 million Americans, nearly 20 percent of the population, are lost in this health-coverage gap. In inner cities, hospitals and trauma centers are closing down or limiting care because of the high cost of providing uncompensated care in an emergency room.

In 1974, Hawaii overcame the reservations of small-businessmen about health-insurance costs by establishing a "community rating." This meant that all the small employers in the state were treated as one risk pool, enabling them to obtain the rate breaks routinely available to big business.

Larger states have balked at such community ratings, although the idea is a way of enticing competitive bids from insurers that would keep costs down and improve long-range health care.

Hawaii's example ought to prove particularly tempting to governors. They should talk to Lewin. It is time to provide health care for everyone.

Lou Cannon is a syndicated columnist.

THE NEW YORK TIMES SUNDAY, JUNE 9, 1991

For Oregon's Health Care System, Triage by a Lawmaker With an M.D.

By TIMOTHY EGAN
Special to The New York Times

SALEM, Ore., June 5 — As an emergency room physician, Dr. John Kitzhaber has spent much of his professional life in the fast-motion treatment of bleeding patients.

Now, as the author of a plan that could make Oregon the first state to insure that health care is provided for all its citizens, Dr. Kitzhaber is trying to use triage on a system that he considers shamefully ill.

Wearing his two hats, as President of the Oregon Senate and as a small-town physician, Dr. Kitzhaber has helped his state fashion a medical plan that is the talk of professional journals. The plan is also being widely discussed in political circles and in countries, including Canada and Britain, that are looking for ways to keep their national health care systems solvent.

His next target is Congress, whose approval is needed within the next year if Oregon is to begin carrying out its groundbreaking plan that ranks and limits care. Dr. Kitzhaber says that the Federal Government has refused to offer anything to the 32 million Americans without health care and that now that the states are trying to solve the problem Congress must show some leadership or get out of the way.

Oregon's plan, part of a package of legislation passed two years ago, would extend Medicaid benefits to all people with incomes below the poverty level and would set a minimum standard of care for those with private insurance. It would do this by rationing treatments, based on a list of what would be covered and what would not. The current system, Dr. Kitzhaber says, rations people.

The Oregon plan represents a major shift in the delivery of health care from the issue of who is covered, to what is covered.

If the plan is to proceed, Congress must authorize a waiver of the current rules for Medicaid, the health care system for the poor that is jointly financed by the Federal and state governments. Medicaid, created to provide health care for the poor, last year covered less than half the people living below the official poverty level because of inadequate financing by the states and Federal Government.

"If we can force the debate to one between the current system and what Oregon is offering, I'm convinced we will win, because the current system is indefensible," Dr. Kitzhaber said.

Wearing jeans and a floral tie, Dr. Kitzhaber was working the Oregon Legislature in the last days of the session, which is expected to end in mid-June. It has been another year of triumph for his health bill, which was born amid headlines and controversy and has now moved to center stage as one of the most talked-about ideas in health care.

The man behind the experiment is a 44-year-old native of the Northwest who practices politics and medicine with equal fervor. A graduate of Dartmouth College, he received his M.D. from the University of Oregon Medical School and has practiced medicine for 17 years in Roseburg, in the timber country of southwestern Oregon. A liberal Democrat, he was first elected to the Oregon Legislature in 1978, and is in his fourth term as President of the Senate.

The Plan's Birth

Dr. Kitzhaber says his idea was born of frustration at seeing "people we were lopping off on one end of the system ending up in the emergency room." His plan was to have a system that emphasized preventive care, he said, and this was codified in the rationing list.

"Believe me, I'd prefer a Federal solution," Dr. Kitzhaber said, "but we can't wait for Congress to get its act together while 40,000 children in the United States die, every year, before their first birthday."

After much uproar in the early stages of the Oregon plan, criticism in this state has been muted. The priority list, ranking 808 disorders and their treatments based on a formula that is equal parts mathematics and public opinion, has received international attention as a pioneering experiment.

As it is, 204,000 Oregonians who qualify for Medicaid receive a relatively rich package of medical benefits, while those who are not poor enough — mostly people in low-paying jobs — receive nothing. Medicaid would be extended to an additional 77,000 people here, that is, everybody below the Federal poverty level, and the benefits would be trimmed, based on the list.

The cutoff, the line below which public financing would not be provided, is to be drawn in the next few weeks as the state Legislature finishes its budget deliberations. Officials say that if $30 million is added, as expected, to Oregon's current annual share of Medicaid of $237 million, then the line on the list will be drawn somewhere around 600. The 200 or so disorders and treatments that would not be covered include lung transplants, acne, Parkinson's disease, reconstructive breast surgery and terminal AIDS with less than 10 percent chance of survival. Those who are terminally ill can get hospice care, counseling and medication for pain relief through the plan.

Some early critics, among them businesses and groups representing the poor, have largely become allies of Dr. Kitzhaber.

Covering Everybody

"The reason we're winning converts is because everybody in Oregon is going to be covered, one way or the other," he said, "and we're doing it with a concise model for how to contain costs."

Dr. Kitzhaber said the two basic models for national health care — one financed primarily by employers and the other by government — were doomed to failure until they addressed the question of keeping costs down.

"Congress has not had the guts to look at the fundamental question, which is: What medical services are really appropriate and what are not?" he said.

By assuring everyone a minimum level of care — even if that means one system for the rich and one for the poor — the most glaring leaks in the system are covered, he said. As an example, he noted that a family of three with an income of $5,500 a year is considered too wealthy to qualify for Medicaid in most states. But that family would be covered in Oregon.

"That is rationing of health care, and legislative bodies do it every budget cycle," he said.

The Oregon plan is not without critics. In Congress, Representative Henry A. Waxman, Democrat of California, and a leading voice on health care issues, said he was concerned that Oregon set a bad example by taking an already small pie and cutting it into more pieces, taking benefits away from the poorest of society.

A similar complaint was made by members of the Children's Defense Fund, which follows medical and social issues affecting children. "It's not that we object to rationing, per se, it's just that we don't like singling out children, who make up half the Medicaid population, for rationing," said Molly McNulty, a health specialist with the group. "We are not defending the status quo, but we don't see the answer as scaling things back."

Dr. Kitzhaber says he is perplexed at criticism from those with whom he has always felt a political kinship. "They are measuring the Oregon plan against an ideal world, and, of course, it's got problems when you put it that way," he said.

The states, Oregon among them, continue to be the innovators in universal health care, but with mixed results. Hawaii's system requires that employers provide insurance for their workers, but it does not address the poor who are working part time and do not qualify for Medicaid. Massachusetts has a similar plan, but it is threatened by the recession.

Oregon's plan, even the part that requires employers to provide insurance, would use the priority list to keep costs down and still assure a minimum level of care.

In an editorial in last month's Journal of the American Medical Association, the Oregon plan was described as "a bold attempt to maximize health care benefits" and "an ambitious experiment that should be encouraged."

Dr. Kitzhaber says that trying something as innovative as a universal health system is much easier in a state like Oregon, with its population of less than 3 million and its growing economy. "Of course, it helps to be a doctor and President of the State Senate," he said.

This article describes health care reform at the state level.
Copyright © 1991 by The New York Times Company. Reprinted by permission.

BEST COPY AVAILABLE

The following article describes a plan that relies primarily on individual insurance.
Copyright • 1992 by The New York Times Company. Reprinted by permission.

THE NEW YORK TIMES FRIDAY, FEBRUARY 7, 1992

BUSH UNVEILS PLAN FOR HEALTH CARE

$100 Billion Proposal Fills Gap in His Re-Election Bid

By MICHAEL WINES
Special to The New York Times

CLEVELAND, Feb. 6 — President Bush moved today to plug a gap in his election-year domestic plans by proposing several tax incentives and other changes in the law that he said would make quality medical care affordable for every American.

In making his plans public, Mr. Bush joined the Democratic Presidential candidates in proposing ways to improve the nation's health-care system. Like his State of the Union Message last Tuesday, it was introduced with much fanfare, but it was viewed cautiously in some quarters.

White House aides estimated that the plan would cost about $100 billion over the five years that would be required to put it into effect. They offered no specific plan to meet the expense, but they suggested that the money could be raised by limiting the growth of Medicare and Medicaid and by other savings that could be worked out later with Congress.

Growing Public Interest

Asked today how he would pay for the program, Mr. Bush replied, "We'll figure that out."

As a practical matter, Mr. Bush's plan has no chance of becoming law because the Democrats who control Congress are offering distinctly different plans. But his entrance into the debate over a topic that has generated a great deal of interest among the public increases the likelihood that some health insurance plan will be enacted in the next few years.

Under Mr. Bush's plan, poor people would receive tax credits and families with incomes of up to $80,000 would be granted tax deductions to help pay for medical insurance. Mr. Bush would also change laws to guarantee that even the chronically ill could find insurance coverage, and he would induce Medicare and Medicaid patients to use health maintenance organizations and other alternatives that are less expensive than private doctors.

Lawmakers of both parties and the Democratic Presidential candidates are backing more ambitious measures to overhaul the existing health care system. For example, one Democratic bill, approved last month by the Senate Labor and Human Resources Committee, would require employers to provide medical insurance for their employees or pay an additional tax to finance a Government insurance plan.

Other plans under consideration range from full-scale, Government-paid national health insurance to a proposal by conservatives that would require all Americans to buy private medical insurance.

On Capitol Hill today, Democrats called the Bush plan inadequate. Some Republicans endorsed it, while others merely said they were happy Mr. Bush had become involved in the debate.

The immediate effect of today's announcement is to allow the White House to say that it is addressing the issue of health care in the election campaign. Mr. Bush had hoped to avoid the issue until after the election, but his hand was forced last fall when former Attorney General Dick Thornburgh was upset in an election for a Pennsylvania Senate seat by a Democrat who made affordable health insurance his main issue.

Aid for 95 Million

In Mr. Bush's speech before the Greater Cleveland Growth Association, he called his new package "the right plan" that would lower medical and insurance costs for 95 million citizens, including many of the estimated 35 million, or 13 percent of the population, who now lack health insurance.

But much of his address was spent in a slashing attack on the Democratic proposals, which he called "a cure worse than the disease."

Mr. Bush's plan relies mostly on financial incentives to make the existing health care system more complete and efficient. Most of the Democratic proposals and some of those offered by Republicans envision a greater Federal role in insuring care for the poor.

Arguing that his plan "will preserve what works and reform what doesn't," Mr. Bush said: "When we talk about health care, we're talking about matters of the most personal nature — in some cases, literally, life and death decisions."

"We don't need to put Government between patients and their doctors," he added. "We don't need to create another wasteful Federal bureaucracy."

The President's address drew but a tepid response from the crowd of Cleveland business leaders, who interrupted it only once, when they applauded an attack on rising malpractice costs.

On Capitol Hill today, George J. Mitchell of Maine, the Senate Democratic leader, called Mr. Bush's plan "woefully inadequate," and Senator John D. Rockefeller 4th of West Virginia, a leading Democrat on health issues, said it was "little more than a timid gesture."

Senator John H. Chafee of Rhode Island, the chief sponsor of a Republican health bill, said Mr. Bush's offering was a "welcome addition to the national debate."

Under the President's plan, the maximum credit or deduction would be $1,250 for a single person, $2,500 for a couple and $3,750 for families with children. The amount of credit or deduction would fall as income rose. Individuals with incomes above $50,000, single parents with incomes over $65,000 and couples with incomes over $80,000 would not be entitled to deductions.

Covering Cost of Basic Plan

Those who already receive Medicaid, Medicare or other Federal health benefits would not be eligible. Medicaid, the Government health plan for poor peo-

cont. on p. A - 27

Revamping Health Care: Highlights of the Bush Proposal

- A voucher worth up to $3,750 to poor families that could be used only to buy medical insurance.
- A tax deduction up to $3,750 for families with incomes up to $70,000 and a lower deduction for those with incomes from $70,000 to $80,000. There would be no deduction for families with incomes higher than $80,000.
- Full deductions of medical insurance premiums for the self-employed.
- A requirement that companies provide coverage to anyone willing to pay for it, regardless of pre-existing medical conditions.
- Inducements for small businesses to band together to buy medical insurance for their employees, lowering their cost by spreading the risk.
- Changes in medical malpractice and antitrust laws to hold down medical costs.
- The encouragement of health maintenance organizations in private plans, Medicare and Medicaid.

The following articles describe an employer mandate plan.
"An affordable health-care plan for all" is reprinted by permission of the author.
"Troubled health care system" is reprinted courtesy of The Boston Globe.

THE BOSTON GLOBE • THURSDAY, JUNE 6, 1991

An affordable health-care plan for all

EDWARD M. KENNEDY

WASHINGTON

For many years, health care has been the fastest growing failing business in America. After nearly three decades of neglect since Medicare and Medicaid were enacted in 1965, the nation's health system now faces a crisis that affects every citizen.

Yesterday, with Senate Majority Leader George Mitchell, Don Riegle, Jay Rockefeller and other Democratic senators, I introduced comprehensive legislation to meet this crisis. Our goals are to guarantee all Americans access to affordable health insurance, and to place strict controls on the soaring cost of health care.

As we have seen in recent weeks, President Bush can get the best health care. So can members of Congress. But most Americans can't. The current system is an obstacle course for patients, doctors, hospitals and insurance companies alike.

Thirty-four million Americans have no health insurance today, and the number is rising every year. Sixty million more Americans have insurance that even the Reagan administration said in 1987 would be inadequate in the event of a serious illness. In other words, nearly 40 percent of the US population has no coverage or inadequate coverage.

Congress guilty of malpractice

Runaway costs are pricing health care out of the reach of average families, and becoming a major impediment for US enterprises struggling to compete in world markets against firms from nations where health-care costs are far lower. For years, successive Congresses and administrations have been guilty of malpractice for refusing to act.

Employers today are increasingly cutting back coverage for workers or dropping it. Their premiums are too high because too many other firms refuse to provide any coverage. Insurance-company practices mean that people with health problems find it difficult or impossible to obtain coverage at any price. Large numbers of Americans are one job loss, one job change or one serious illness away from being uninsured.

If you lose your job, you lose your health insurance. What kind of country lets that happen? If you have a new baby, the basic care needed to get a healthy start in life usually isn't covered. If you change jobs, you may not be able to get health insurance. When your children turn 21, they lose their coverage under your family policy. If you have a chronic illness, you can't get coverage at any price. If you're in a serious automobile accident, you may die while the rescue unit tries to decide whether the nearest hospital emergency room will take you. If your boss feels coverage is too expensive, he can cancel the company's group policy and leave you on your own.

Paying more, getting less

Situations like these are becoming the rule, not the exception, in today's health-care system. A health-care Sword of Damocles is hanging over every family.

The paradox of the American health-care system is that the nation is paying more for its care and getting less value for its dollar. In 1970, the country spent $75 billion in public and private funds on health. Last year, the total reached $676 billion, and the figure is continuing to rise at near double-digit rates that far outstrip increases in wages or growth in the economy. Since 1980, out-of-pocket costs – those not covered by insurance – have soared from $63 billion to $162 billion. Health-care expenses paid by business now exceed corporate profits. We spend more per person than any other nation for health care – 40 percent more than Canada and twice as much as Germany or Japan.

The legislation we introduced – called "HealthAmerica" – deals with these problems in several ways.

First, in the "play or pay" feature of the plan, all businesses will be required to provide basic health insurance to employees and their families, or else pay a percentage of their payroll – approximately 7 percent – to the federal government to fund comparable coverage through a new public insurance plan, to be called "AmeriCare," which will be available to all citizens who do not have private health insurance.

Each firm will make a calculation as to whether it prefers to insure its workers or contribute to the public plan for their coverage. The play-or-pay option will substantially reduce the burden of providing coverage for small businesses and for employers with low-wage or part-time workers. The majority of employers today already provide health insurance voluntarily, but a large minority do not. Under our plan, all businesses will do their fair share at a reasonable cost.

AmeriCare would be a federal-state program to replace Medicaid and cover all Americans not receiving Medicare or on-the-job insurance. Workers whose employers choose to contribute to the public plan rather than provide private insurance would receive their coverage through AmeriCare. The unemployed would be able to obtain coverage under AmeriCare by paying premiums based on ability to pay.

In both AmeriCare and job-based coverage, standard hospital and medical bills would be paid. Routine deductibles and co-insurance would be permitted, but pre-existing condition exclusions and other provisions that unreasonably deny protection woud be prohibited, and a cap would be placed on out-of-pocket costs for covered services.

In addition, the legislation would establish strict controls over costs.

Unnecessary care costs the nation an estimated $18 billion a year. Studies by the Rand Corporation of selected surgical procedures found that 15 to 40 percent were unnecessary and potentially harmful. Under our plan, guidelines for responsible medical practice would be adopted to reduce this waste and abuse.

The current system of paying for care through 1,200 different insurance companies is a major additional part of the cost problem. Company overhead, advertising expenses, and excessive profits eat up as much as 50 percent of the premiums for policies purchased by small companies and individual citizens. Dealing with so many insurance companies, and with forms and administrative procedures, also imposes significant costs on doctors and hospitals, which are passed on to patients.

Our legislation would reform the insurance market, so that more of the premiums would pay for actual health care. All but the largest insurance firms would be required to

cont. on p. A - 26

cont. from p. A - 25

join a single consortium in each state to doctors and hospitals. With economies of scale, standardized forms, and simplified procedures, most claims could be handled electronically, and bill-processing costs cut in half.

The plan recognizes the special problems of small business in a number of ways, such as new tax credits to help meet the cost of covering workers, and special phase-in rules to ease the burden. In addition, the insurance market reforms would make coverage significantly more affordable for small firms.

Finally, a Federal Health Expenditure Board, modeled on the Federal Reserve Board, would be created as an independent agency to set health-care budget goals. The board would have the responsibility to implement and oversee national negotiations involving representatives of hospitals, physicians and insurers to set reasonable rates and allocate overall priorities in spending for health care. The board would also encourage the states to take similar steps to meet their priorities for health care within the national goals.

Nothing comparable in health-care cost containment has ever been undertaken before. This proposal may offer the last best chance to deal with the festering problem of runaway costs.

The plan has significant costs for the federal budget – an estimated $6 billion in the first year, and substantially more in the years when HealthAmerica is phased in. These budget costs would have to be met by a combination of cuts in existing federal programs and new federal revenues in order to avoid adding to the current massive budget deficit.

Can the nation afford this program? I believe we must because it is the only realistic way to address the crisis before it becomes far worse and costs the country far more.

The key point on costs, however, is that unlike almost all other forms of federal spending, additional spending on sensible health reform saves money in the long run.

The plan we propose is not national health insurance, and it is not the Canadian model, neither of which can be passed by Congress under a Republican administration. This plan is a practical alternative that is comprehensive and fair, and it deserves the support of both Congress and the Bush administration. It is capable of ending the crisis while preserving the single most valuable feature of the existing system, the public private-partnership that has been the real strength of American health care in the past and that can be its real strength in the future.

Edward M. Kennedy is the senior senator from Massachusetts.

THE BOSTON SUNDAY GLOBE June 11, 1991

Troubled health care system

Major features of Senate Democrats' new blueprint

To achieve universal health insurance:

■ Within five years of passage, all Americans receive health coverage through the work place or new federal-state program called AmeriCare.

■ AmeriCare plans, run by each state under national standards, would replace Medicaid for acute care and include all those not covered through the workplace.

■ Employers would have to "play or pay" – i.e., offer health insurance voluntarily or pay a 6 to 8 percent payroll tax to fund AmeriCare plans. Low-income subscribers would get premium subsidies, whether insured privately or through AmeriCare.

To control costs of health care:

■ New Federal Health Expenditure Board representing medicine, hospitals, insurers, employers, government and other parties would set national yearly spending goals and convene negotiations between payers and providers to bargain over rates; agreement would be binding.

■ New federal board would also develop standardized billing forms to reduce administrative costs of doctors and hospitals.

■ States would establish consortia to pay claims of small insurance companies, reducing administrative costs.

■ Government would step up efforts to establish guidelines on appropriate medical practice, assess medical technology and encourage managed care plans to discourage unnecessary care.

To address special concerns of small businesses:

■ Federal standards would reform small-group health insurance market, making coverage affordable to more small businesses. Standards would eliminate exclusion of people with pre-existing medical conditions or health risks and require community-wide premium-setting.

■ Phase in "play or pay" mandate, starting with larger businesses and working downward over five years, allowing firms to insure voluntarily or plan ahead. If at least 75 percent of businesses in each size group insured workers voluntarily, the rest would be exempt from paying AmeriCare payroll taxes.

■ New small businesses would have two-year exemption from "play or pay" mandates, and a 50 percent break in third-year payroll taxes.

■ Federal government would give new tax breaks to self-employed and marginally profi[illegible] small businesses.

The following article describes a national health insurance plan.
Reprinted by permission of the author.

THE CHRISTIAN SCIENCE MONITOR Tuesday, September 10, 1991

Single-Payer System Guarantees Health Care for Less

By Marty Russo

EVERYONE agrees that our health-care system needs reform. Health-care costs are spiraling while more Americans are being priced out of the system. We spend more on health than any other nation in the world, yet our health statistics are poorer than most other industrialized countries.

We need reforms which guarantee universal health care while cutting billions in wasteful administrative costs. A single-payer health insurance system does both. The General Accounting Office (GAO) and the Congressional Budget Office (CBO) have testified that a single-payer system can guarantee comprehensive health care to all Americans for less than we spend now.

This year I introduced H.R. 1300, the Universal Health-Care Act of 1991, which would strengthen every American's ability to select the doctor of his or her choice. It replaces our nation's 1,500-plus insurance companies with a single, publicly administered and accountable program and uses the substantial savings to provide universal care and eliminate copayments and deductibles. The bill would cover all Americans for a wide range of benefits including hospital and physician care, long-term care, prescription drugs, mental health services, dental care, and preventive care. Consumers would still be free to choose their own doctors, hospital, or health-care provider.

My proposal incorporates many of the strengths of the health-care system that's been so successful in Canada. But it is not a Canadian system; it's an American one. It's about the things Americans have come to expect: freedom of choice, quality care, and the efficient and fair use of their hard-earned dollars. It's about giving Americans the peace of mind they deserve so that when their children are ill they can take them to a doctor without having to pay a high deductible; or when they change jobs, they won't lose their health insurance; or when their parents need long-term care, they will not have to mortgage their home.

Ninety-five percent of Americans would save money under the bill and skyrocketing health-care costs would finally be capped. Rapidly escalating health-insurance premiums, copayments, and deductibles would be replaced with modest increases in payroll taxes, personal and corporate income taxes, and state and federal contributions. Under the plan, a family of four with $54,000 in income would save $1,750 a year.

A single-payer system would dramatically reduce costs because all Americans would be covered under a single comprehensive program. Money would no longer be wasted on weeding out unprofitable groups and individuals, or on advertising, marketing, and commissions, or on billing millions of consumers. Doctors, nurses, and hospitals would no longer have to keep track of the eligibility requirements or complicated definitions of services in insurance plans.

According to a recent report by the GAO, shifting to a single-payer system would save the US $67 billion in administrative costs alone. These savings would not only finance high-quality care for the uninsured, but would benefit middle-income Americans by eliminating all copayments and deductibles.

The bill would hold down costs by establishing national and state health-care budgets. Fee schedules would be established so that physicians would know in advance how much they would receive for a specified service. Hospitals would be paid monthly, based on a global budget established at the beginning of the year. All of these measures have been cited by the GAO and the CBO as the most effective ways to contain costs.

We can't afford to do anything less than single-payer. Partial solutions like insurance reform or mandated benefits won't work. Quality would continue to decline as insurers increased their role in medical decision-making and costs would continue to rise. I'm tired of hearing that a single-payer is the best system but could never happen in the US. For the amount of money we now spend, Americans should be living two years longer than Canadians, not the other way around. H.R. 1300 doesn't answer every detail. But it does offer the framework for how health reform should be structured to guarantee that America has the best health-care system in the world – not just the most expensive.

■ *Rep. Marty Russo (D) of Illinois is a member of the House Ways and Means Committee.*

---

cont. from p. A - 24

ple, covers 30 million people, but that is only about 40 percent of people below the poverty level. More than 35 million people have no medical insurance, while 34 million are covered by the Medicare program for the elderly and the disabled. About 177 million people, including many enrolled in Medicare, have some type of private insurance.

Taxpayers who are self-employed would be allowed to deduct the entire cost of their health insurance under the Bush plan regardless of income, up from the present 25 percent.

Today, $3,750 would be enough to buy the most basic family medical insurance. Mr. Bush would increase the maximum credits and deductions annually to offset the effect of inflation. But the increases would be tied to the rate of overall inflation, which was 3.1 percent in the last 12 months, not the higher rate of inflation in medical costs, which was about 11 percent, so the value of the tax benefits could gradually be eroded.

The tax credit for poor people would help defray some of the cost of subscribing to employer health plans. It could also help buy private insurance or a basic package of benefits that all insurers would be required to offer.

Proposals on Insurance

In addition to the tax changes, Mr. Bush proposed legislation that the White House said would make the insurance business more competitive and equitable.

One change would outlaw "cream-skimming," a practice in which insurers provide coverage only to profitable low-risk groups and curtail coverage or raise prices for policies that cover persons who are often sick or at risk of catastrophic illnesses.

Mr. Bush's plan would require insurers to provide coverage to anyone who sought it and to abolish "pre-existing conditions" clauses that limit coverage for new employees. Many workers today are unable to change jobs because they cannot obtain medical insurance from a new employer.

A second proposal would encourage small businesses to band together to buy insurance, spreading the risk among them. Mr. Bush's visit to Cleveland was scheduled in part because the city is home to an organization that has lowered health insurance costs for about 10,000 small companies that way.

Sources of Additional Information

In addition to following news coverage of health care reform, you can obtain information from these sources.

Advocates of Individual Insurance

Heritage Foundation
214 Massachusetts Ave. NE
Washington, DC 20002
(202) 546-4400

President George Bush
The White House
Washington, DC 20500
(202) 456-1414

Advocates of Employer Mandates

Senator George Mitchell (D-ME)
United States Senate
Washington, DC 20510
(202) 224-3121

The American Medical Association
515 N. State Street
Chicago, IL 60610
(312) 464-5374

KS Employer Coalition on Health
1271 Harrison
Topeka, KS 66612
(913) 233-0351

Advocates of National Health Insurance

Physicians for a Nat'l Health Program
Cambridge Hosp./Harvard Med. School
1493 Cambridge St.
Cambridge, MA 02139
(617) 661-1064

Citizen Action
1300 Conn. Ave. NW, Suite 401
Washington, DC 20036
(202) 857-5153

Senator Bob Kerrey (D-NE)
U.S. Senate
Washington, DC 20510
(202) 224-3121

Organizations seeking citizen input on medical ethics

American Health Decisions (AHD) is a coalition of citizen organizations concerned about health care ethics, including health care reform. Below is a list of state organizations that belong to AHD. If your state is not listed, contact Judy Hutchinson at Colorado Speaks Out On Health for information on a resource package for starting your own Community Health Decisions project.

Arizona Health Decisions
Box 4401
Prescott, Arizona 86302
(602) 778-4850

California Health Decisions
505 S. Main St., Suite 400
Orange, California 92668
(714) 647-4920

Colorado Speaks Out On Health
Center for Health Ethics & Policy
1445 Market St., Suite 380
Denver, Colorado 80202
(303) 820-5635

Georgia Health Decisions
Eggleston Children's Hospital
1405 Clifton Rd.
Atlanta, Georgia 30322
(404) 378-4764

Acadia Institute
118 West St.
Bar Harbor, Maine 04069
(202) 288-4082

Massachusetts Health Decisions
PO Box 417
Sharon, Massachusetts 02067
(617) 784-1966

Midwest Bioethics Center
410 Archibald, Suite 106 •
Kansas City, Missouri 64111
(816) 756-2713

Nebraska Health Decisions
Lincoln Medical Center Assoc.
4600 Valley Rd.
Lincoln, Nebraska 68510
(402) 483-4537

Citizens' Committee on
Biomedical Ethics, Inc.
Oakes Outreach Center
120 Morris Ave.
Summit, New Jersey 07901-3948
(908) 277-3858

New Mexico Health Decisions
501 Carlyle Blvd.
Albuquerque, New Mexico 87106
(505) 255-6717

New York Citizens' Committee
350 Fifth Ave., Suite 1118
New York, New York 10118
(212) 268-8900

Bioethics Resource Group
118 Colonial Ave.
Charlotte, North Carolina 28207
(704) 332-4421

Oregon Health Decisions
921 SW Washington, Suite 723
Portland, Oregon 97205
(503) 241-0744

Tennessee Guild for
Health Decisions
CCC-5319 Medical Center North
Vanderbilt University Medical Ctr.
Nashville, Tennessee 37232-2351
(615) 883-3248

Vermont Ethics Network
103 South Main St.
Waterbury, Vermont 05676
(802) 241-2920

Center for Health Ethics and Law
University of West Virginia
107 Crestview Dr.
Morgantown, West Virginia 26505
(304) 598-3484

Wisconsin Health Decisions
Lawrence University
Program in Bioethics
Box 599
Appleton, Wisconsin 54912

Suggestions for Leading *The Health Care Crisis in America*

All discussion groups are different. The participants, the dynamics of your particular group, and the nature of public affairs at the time of the discussion make this so. The following suggestions are not intended to be definitive, but rather to be representative of what other leaders have found useful as they have guided similar discussions.

The leader's job is to strike a balance between freedom and focus. To achieve the rewards that come when participants learn from each other, the leader must accept the risks that come from the spontaneity of individuals offering their unique insights. Your discussion session will be more successful and more fun if participants can share their opinions in a relaxed atmosphere, so enjoy yourself!

If your group is devoting only one session to the health care crisis, we suggest that you use Part I as the basis of your discussion rather than trying to squeeze both parts into one two-hour session. Even if you use just Part I and do not go on to discuss particular policy proposals, participants can still reflect on what they value in a health care system and work together to think about the difficult tradeoffs that must be addressed by policymakers.

Preparing for the discussion

As you prepare for the session devoted to Part I, think in terms of this general timetable for a two-hour session:

1) introductions, an overview of the general ground rules for a study circle, and a brief discussion of participants' personal concerns about America's health care system (approximately half an hour);

2) a discussion of the ethical issues raised by health care reform (about an hour); and

3) a closing that brings out group member ideas about what they most value in a health care system (the remaining half-hour).

If you hold a second session, think in terms of this general timetable:

1) a brief review of study circle ground rules and of the first session (approximately half an hour);

2) a discussion of reform efforts at the state level (about half an hour);

3) a discussion of reform efforts at the national level, and closing (the remaining hour).

Introductions and explaining the ground rules

Begin by asking participants to introduce themselves. Make sure that everyone understands what a study circle is and what is expected of participants. You may wish to say something like the following: "My role is to assist in keeping discussion focused and moving along. Your role is to share your concerns and beliefs with each other. You should be willing

to examine your own beliefs in light of what others say, and that will require listening carefully to others."

Beginning the discussion

In the beginning of the discussion you should draw out participants' concerns about the U.S. health care system. As participants share their concerns with each other, they will be laying the groundwork for their discussion of both ethical and policy issues. You may wish to provoke this discussion by asking one of the following questions:

How have your own experiences with the health care system, or the experiences of people you know, affected your ideas about the health care situation in our country?

What do you think are the most serious problems with our health care system?

Which of these problems ought to be our top priority to solve?

Discussing ethical issues

The remainder of the session should focus on the ethical issues presented in Part I. The purpose is for participants to reflect on what they value in a health care system, hear others' views, and work together to think about the difficult choices our society will have to make.

Guide the discussion along the lines of its presentation in Part I, but don't feel that you must stick with the order in which issues are presented. Let the conversation develop naturally, but help the group continue to focus on the most important issues. Some possible questions for guiding this session are:

Does our society have an obligation to provide health care to all its members? What are the beliefs and values that influence your answer?

If health care is a right, what kind of health care is everyone entitled to? How much health care?

What are the limits of society's responsibility? How should we decide the limits?

The other two issues (the role of government and rationing) will probably come up in the context of your discussion of whether access to health care is a right, but you can raise these key issues by using some of the many questions that are provided in the text. Some of these questions are:

How much power should government have to direct the health care system? What are the arguments for and against a strong role for government in this arena?

How much power should the private sector have in making basic decisions about health care? What are the arguments for and against a strong role for the private sector?

Should employers continue to be the primary insurance providers in our society? What are some of the advantages and disadvantages of this system? Is this setup consistent with the values you consider to be most important?

Should we explicitly limit treatment for some in our society in order to provide basic treatment for all? What are the beliefs and values that influence your answer?

If you think that we should explicitly ration treatment, how should we decide who gets what treatments?

Closing the discussion of ethical issues

Your discussion of ethical issues should conclude with an attempt to discover what participants value most in a health care system. You might ask:

What would you most like to communicate to policymakers about what our health care system should provide?

Many of us value equality, social responsibility, individual responsibility, and freedom of choice. What other values and beliefs have been raised in this discussion? Since no health care system can fully satisfy all of our values, what values do you think are most important to fulfill?

If your group is holding just one session, thank participants for attending and for sharing their views with the group. Give them and yourself a few minutes to fill out the "Follow-up Form." We would greatly appreciate your collecting and sending in these forms or asking participants to return them. The information they provide will help us as we develop future programs.

If you will be devoting a second session to the health care crisis, we suggest that you or members of your group research your state's health care system. Part II describes how to do such research. If you already have a good article describing your state's system, you should hand it out at the end of this first session.

Discussing policy issues: An optional second session

We suggest that you divide this session into two parts: (1) a discussion of reform efforts by state governments and (2) a discussion of plans for reform at the national level.

Possible questions for guiding the discussion of state reform efforts include:

How do Hawaii's and Oregon's plans deal with the issues of access and controlling costs?

What are the advantages of each of these plans? the disadvantages?

How does our state deal with the key issues of access and controlling costs?

Are there any lessons from other states that might be applied in our state?

What types of changes do you think should be made in our state's system? Is anyone in this state promoting them? What is the likelihood that those changes will be made?

To introduce ideas for reform at the national level, ask participants to briefly explain the three general approaches. Remind them that they may wish to draw on the newspaper articles that describe the specific proposals.

For each of the approaches, ask: *What does this approach call for?*

For each of the approaches, ask: *What do its supporters hope to achieve?*

A free-wheeling discussion and debate on the three approaches can follow. Some possible questions for guiding this part of the discussion are:

How does this approach attempt to deal with the problem of access?

How does this approach attempt to deal with the problem of controlling costs?

For any one of the approaches ask: *What do you see as the major strengths of this approach? What are the principal drawbacks of this approach?*

For any one of the approaches ask: *What values does this approach emphasize? To what values does this approach give less emphasis?*

What are the most important elements that we should include in any health care reform plan? Remind the group that they might find elements that they like from each approach.

Would it be feasible to combine your favorite elements from several of the approaches? What would your combination achieve? At what monetary cost? At what cost in values?

In closing, ask participants to share whether and how their thinking has changed as a result of the discussion. Encourage them to talk about points where they remain unsure. If discussion were to be continued, what points would they like to consider? What points would they like to communicate to policymakers?

Please allow time at the end of your discussion for completing the "Follow-up Form." The feedback you provide by collecting and returning the forms will help us in the development of future programs.

Leading a Study Circle

The study circle leader is the most important person in determining its success or failure. It is the leader's responsibility to moderate the discussion by asking questions, identifying key points, and managing the group process. While doing all this, the leader must be friendly, understanding, and supportive.

The leader does not need to be an expert. However, thorough familiarity with the reading material and previous reflection about the directions in which the discussion might go will make the leader more effective and more comfortable in this important role.

The most difficult aspects of leading discussion groups include keeping discussion focused, handling aggressive participants, and keeping one's own ego at bay. A background of leading small group discussions or meetings is helpful. The following suggestions and principles of group leadership will be useful even for experienced leaders.

• **"Beginning is half," says an old Chinese proverb.** Set a friendly and relaxed atmosphere from the start. A quick review of the suggestions for participants will help ensure that everyone understands the ground rules for the discussion.

• **Be an active listener.** You will need to truly hear and understand what people say if you are to guide the discussion effectively. Listening carefully will set a good example for participants and will alert you to potential conflicts.

• **Stay neutral and be cautious about expressing your own values.** As the leader, you have considerable power with the group. That power should be used only for the purpose of furthering the discussion and not for establishing the correctness of a particular viewpoint.

• **Utilize open-ended questions.** Questions such as, "What other possibilities have we not yet considered?" will encourage discussion rather than elicit short, specific answers and are especially helpful for drawing out quiet members of the group.

• **Draw out quiet participants.** Do not allow anyone to sit quietly or to be forgotten by the group. Create an opportunity for each participant to contribute. The more you know about each person in the group, the easier this will be.

• **Don't be afraid of pauses and silences.** People need time to think and reflect. Sometimes silence will help someone build up the courage to make a valuable point. Leaders who tend to be impatient may find it helpful to count silently to 10 after asking a question.

• **Do not allow the group to make you the expert or "answer person."** You should not play the role of final arbiter. Let the participants decide what they believe. Allow group members to correct each other when a mistake is made.

• **Don't always be the one to respond to comments and questions.** Encourage interaction among the group. Participants should be conversing with each other, not just with the leader. Questions or comments that are directed at the leader can often be deflected to another member of the group.

• **Don't allow the group to get hung up on unprovable "facts" or assertions.** Disagreements about basic facts are common for con-

troversial issues. If there is debate over a fact or figure, ask the group if that fact is relevant to the discussion. In some cases, it is best to leave the disagreement unresolved and move on.

• **Do not allow the aggressive, talkative person or faction to dominate.** Doing so is a sure recipe for failure. One of the most difficult aspects of leading a discussion is restraining domineering participants. Don't let people call out and gain control of the floor. If you allow this to happen the aggressive will dominate, you may lose control, and the more polite people will become angry and frustrated.

• **Use conflict productively and don't allow participants to personalize their disagreements.** Do not avoid conflict, but try to keep discussion focused on the point at hand. Since everyone's opinion is important in a study circle, participants should feel safe saying what they really think – even if it's unpopular.

• **Synthesize or summarize the discussion occasionally.** It is helpful to consolidate related ideas to provide a solid base for the discussion to build upon.

• **Ask hard questions.** Don't allow the discussion to simply confirm old assumptions. Avoid following any "line," and encourage participants to re-examine their assumptions. Call attention to points of view that have not been mentioned or seriously considered, whether you agree with them or not.

• **Don't worry about attaining consensus.** It's good for the study circle to have a sense of where participants stand, but it's not necessary to achieve consensus. In some cases a group will be split; there's no need to hammer out agreement.

• **Close the session with a brief question that each participant may respond to in turn.** This will help them review their progress in the meeting and give a sense of closure.

Suggestions for Participants

The goal of a study circle is not to learn a lot of facts, or to attain group consensus, but rather to deepen each person's understanding of the issue. This can occur in a focused discussion when people exchange views freely and consider a variety of viewpoints. The process – democratic discussion among equals – is as important as the content.

The following points are intended to help you make the most of your study circle experience and to suggest ways in which you can help the group.

• **Listen carefully to others.** Make sure you are giving everyone the chance to speak.

• **Maintain an open mind.** You don't score points by rigidly sticking to your early statements. Feel free to explore ideas that you have rejected or failed to consider in the past.

• **Strive to understand the position of those who disagree with you.** Your own knowledge is not complete until you understand other participants' points of view and why they feel the way they do. It is important to respect people who disagree with you; they have reasons for their beliefs. You should be able to make a good case for positions you disagree with. This level of comprehension and empathy will make you a much better advocate for whatever position you come to.

• **Help keep the discussion on track.** Make sure your remarks are relevant; if necessary, explain how your points are related to the discussion. Try to make your points while they are pertinent.

• **Speak your mind freely, but don't monopolize the discussion.** If you tend to talk a lot in groups, leave room for quieter people. Be aware that some people may want to speak but are intimidated by more assertive people.

• **Address your remarks to the group rather than the leader.** Feel free to address your remarks to a particular participant, especially one who has not been heard from or who you think may have special insight. Don't hesitate to question other participants to learn more about their ideas.

• **Communicate your needs to the leader.** The leader is responsible for guiding the discussion, summarizing key ideas, and soliciting clarification of unclear points, but he/she may need advice on when this is necessary. Chances are you are not alone when you don't understand what someone has said.

• **Value your own experience and opinions.** Everyone in the group, including you, has unique knowledge and experience; this variety makes the discussion an interesting learning experience for all. Don't feel pressured to speak, but realize that failing to speak means robbing the group of your wisdom.

• **Engage in friendly disagreement.** Differences can invigorate the group, especially when it is relatively homogeneous on the surface. Don't hesitate to challenge ideas you disagree with. Don't be afraid to play devil's advocate, but don't go overboard. If the discussion becomes heated, ask yourself and others whether reason or emotion is running the show.

• **Remember that humor and a pleasant manner can go far in helping you make your points.** A belligerent attitude may prevent acceptance of your assertions. Be aware of how your body language can close you off from the group.

Follow-up Form

Please take a few minutes to complete and return this follow-up form. Your answers will help us improve the Public Talk Series material and make it a more valuable resource.

1) Did you use *The Health Care Crisis in America?* ___ yes ___ no
If so, how? (check all that apply)
___ in a discussion group ___ for reference or research material ___ for lecture or classroom use

2) What did you think of the program?

	very good				poor
content	1	2	3	4	5
format	1	2	3	4	5
balance, fairness	1	2	3	4	5
suggestions for leaders	1	2	3	4	5
suggestions for participants	1	2	3	4	5
supplemental readings	1	2	3	4	5

3) Please answer the following if you held or were part of a discussion group.

Your role was ___ the organizer ___ the discussion leader ___ a participant

What was the sponsoring organization (if any)? _____

How many attended? _____

Where was the program held? city _____ state _____

How many times did your group meet to discuss this topic? ___

Participants in this discussion group (check all that apply)
___ came together just for this discussion
___ hold discussions regularly
___ meet regularly, but not usually for issue-oriented discussion

Would you use study circles again? ____ yes ____ no

4) What future topics would you like to see in SCRC's Public Talk Series?

5) Other comments?

Name _____

Organization _____

Address _____

_____

_____

Phone _____

Please return to the Study Circles Resource Center, PO Box 203, Pomfret, CT 06258
or FAX to (203) 928-3713.
See reverse side for information on other Public Talk Series programs.

Public Talk Series Programs and Other Resources Available from the Study Circles Resource Center

Publications of the Study Circles Resource Center (SCRC) include topical discussion programs; training material for study circle organizers, leaders, and writers; a quarterly newsletter; a clearinghouse list of study circle material developed by a variety of organizations; and a bibliography on study circles, collaborative learning, and participatory democracy. Prices for topical programs are noted below. (You are welcome to order single copies and then photocopy as necessary for your group.) Other resources from SCRC are free of charge.

Topical discussion programs

(prices are noted below)

Comprehensive discussion guides

___ *Can't We All Just Get Along? A Manual for Discussion Programs on Racism and Race Relations* - $3.00

___ Election Year Discussion Set - $5.00
- *The Health Care Crisis in America*
- *Welfare Reform: What Should We Do for Our Nation's Poor?*
- *Revitalizing America's Economy for the 21st Century*
- *The Role of the United States in a Changing World*

Public Talk Series programs - $2.00 each

___ 203 - *Revitalizing America's Economy for the 21st Century*

___ 401 - *The Health Care Crisis in America*

___ 501 - *Homelessness in America: What Should We Do?*

___ 302 - *The Right to Die*

___ 301 - *The Death Penalty*

___ 304 - *Welfare Reform: What Should We Do for Our Nation's Poor?*

___ 202 - *American Society and Economic Policy: What Should Our Goals Be?*

___ 303 - *Are There Reasonable Grounds for War?*

___ 106 - *Global Environmental Problems: Implications for U.S. Policy Choices* *

___ 105 - *Facing a Disintegrated Soviet Union* *

___ 107 - *The Arab-Israeli Conflict: Looking for a Lasting Peace* *

___ 104 - *The Role of the United States in a Changing World* *

* based on material developed by the Choices for the 21st Century Education Project of the Center for Foreign Policy Development at Brown University

Other resources from the Study Circles Resource Center

(available at no charge)

Pamphlets

___ "An Introduction to Study Circles" (20 pp.)

___ "Guidelines for Organizing and Leading a Study Circle" (32 pp.)

___ "Guidelines for Developing Study Circle Course Material" (32 pp.)

Resource Briefs (single pages)

___ "What Is a Study Circle?"

___ "Leading a Study Circle"

___ "Organizing a Study Circle"

___ "The Role of the Participant"

___ "Developing Study Circle Course Material"

___ "Assistance with Study Circle Material Development"

___ "What Is the Study Circles Resource Center?"

___ "The Study Circles Resource Center Clearinghouse"

Connections (single-page descriptions of ongoing study circle efforts)

___ Adult Religious Education

___ Youth Programs

___ Study Circle Researchers

___ Unions

Focus on Study Circles (free quarterly newsletter)

___ Sample copy

___ Subscription

Other publications

___ Clearinghouse list of study circle material

___ *Annotated Bibliography on Study Circles, Collaborative Learning, and Participatory Democracy*

Please send in your order, with payment if you order PTS programs, with your follow-up form on reverse.

Study Circles Resource Center • PO Box 203 • Pomfret, CT 06258 • (203) 928-2616 • FAX (203) 928-3713